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IN THE SUPERIOR COURT OF THE STATE OF ARIZONA
IN AND FOR THE COUNTY OF MARICOPA

CHARLES ARNOLD, PUBLIC FIDUCIARY, et al Plaintiffs, v. ARIZONA DEPARTMENT OF HEALTH SERVICES, ARIZONA STATE HOSPITAL, and MARICOPA COUNTY BOARD OF SUPERVISORS, Defendants.	Maricopa County No. C-432355 ORDER ADOPTING STRATEGIC PLAN FOR DUAL DIAGNOSIS (Assigned to the Honorable Bernard J. Dougherty)

The Court has reviewed the Joint Stipulation to Approve Strategic Plan for Dual Diagnosis signed by the Plaintiffs and the state Defendants, and

ORDERS THAT:

The Strategic Plan for Dual Diagnosis is approved and made a part of the Supplemental Agreement dated December 22, 1998.

Hon. Bernard J. Dougherty
Maricopa County Superior Court

COPY of the foregoing hand-delivered this 17th day of June, 1999, to:

The Honorable Bernard J. Dougherty
Superior Court of Maricopa County
201 West Jefferson, Suite 8-B
Phoenix, Arizona 85003

COPY of the foregoing mailed this 17th day of June, 1999, to:

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ValueOptions

and

ADHS/DBHS

STRATEGIC PLAN

FOR

Dual Diagnosis

March 1, 1999

ARIZONA DEPARTMENT OF HEALTH SERVICES
Division of Behavioral Health Services
ValueOptions

DUAL DIAGNOSIS INTEGRATION PLAN

INTRODUCTION

Like many other states, Arizona is now ready to confront the reality that the majority of recipients of behavioral health services suffer from both substance abuse and mental health disorders. According to the Epidemiological Catchment Area Studies of 1980 and 1984, the presence of mental disorder triples the risk of a co-occurring substance abuse, and the presence of substance abuse quadruples the risk of mental disorder. Yet, our training, funding sources, laws, and practices all support a system that treats mental illness and substance abuse as almost mutually exclusive conditions. Most treatment programs are staffed by clinicians who have been taught to serve either substance abusers or mentally disordered individuals; state laws for the definition of "mental disorder" and for involuntary treatment sharply distinguish between substance abuse and other behavioral health disorders; and both state and federal funding streams are both separately targeted for either mental or substance abuse disorders.

Through this initiative, ADHS/DBHS plans to investigate best practices, identify and remove barriers, and provide incentives for providers to integrate mental health and substance abuse treatment to better serve individuals with co-occurring disorders.

DUAL DIAGNOSIS INTEGRATION PLAN

INTERNAL/EXTERNAL ASSESSMENT

STRENGTHS	WEAKNESSES
Substance abuse and mental health programs are under a single State administration; Providers are interested in integrating substance abuse and mental health treatment; ADHS/DBHS program staff are knowledgeable and dedicated to the principles of services integration.	Education of provider staff excludes significant information on either substance abuse or mental health treatment; lack of cross -training opportunities. Mental Health and Substance Abuse treatment staff have differing outcome expectations; Funding sources do not encourage services integration.
OPPORTUNITIES	**THREATS**
The Service Gap analysis will provide objective data on needed services; The TOPPS II and Dual Diagnosis Integration Grants are both aligned to the goals of this plan.	Resources may not be adequate to implement best practices across all populations and Geographic Service Areas; The time frames required by the grants & lawsuit, and successful community service development may be incompatible.

DUAL DIAGNOSIS INTEGRATION PLAN

I. Proposed Treatment Model[1]

The ADHS/DBHS Integrated Treatment Model for class members with co-occurring mental illness and substance abuse disorders will consist of the following key features:	
1.	Simultaneous treatment of both disorders by the same person, team or organization; single locus of control;
2.	The integrated treatment modality is present in all components of a continuum of care (inpatient settings, acute residential, therapeutic communities, club houses, drop in centers, peer and family support groups, supported housing, and vocational services);
3.	Focus on engagement and motivational aspects of treatment;
4.	Psychopharmacological interventions and modification of pharmacological approaches when necessary;
5.	Assertive outreach, intensive case management and relapse management;
6.	Education of individuals and their families;
7.	Group interventions, peer support and self-help groups, using adjusted outcome expectations;
8.	Goals of the treatment are conceived in stages: acute stabilization, engagement, prolonged stabilization, rehabilitation and recovery.

II. Objectives and Action Steps

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[1]Drake, R.E. Rosenberg, S.D. and Mueser, K.T. (1996). Assessing substance use disorder in persons with severe mental illness. In R.E. Drake and K.T. Mueser (Eds.), Dual diagnosis of maior mental illness and substance abuse. Vol. 2: Recent and Clinical Implications (pp. 3-17). San Francisco: Jossey-Bass.

Minkoff, K. (1989). "Development of an integrated Model for the Treatment of Patients with Dual Diagnosis of Psychosis and Addition." Hospital and Community Psychiatry, 40 (10), 1031-1036.

Minkoff, K., & Drake, R.E. (1991). Conclusion. In K. Minkoff, & R.E. Drake (Eds), Dual diagnosis of maior mental illness and substance abuse disorder (pp. 107-108). San Francisco, CA: Jossey-Bass, Inc.

DUAL DIAGNOSIS INTEGRATION PLAN

Objective 1. Clarify funding and eligibility requirements			
RBHAs and providers and believe they cannot spend "SMI" money on substance abuse services. This is a barrier to development and provision of needed services.			
	Action	By Whom	By When
a.	Conduct internal ADHS/DBHS meeting to clarify fund source assignment requirements;	Mike Priniski, Christy Dye, Michael Franczak, Valinda Mores, Aimee Schwartz, Ann Froio, Carol Smallwood	3/7/99
b.	Eliminate/revise section on program enrollment in the ADHS/DBHS enrollment and eligibility policies; make available for public comment;	ADHS/DBHS Policy Work Group (Teresa Robbens and Carol Smallwood, co-chairs)	6/15/99
c.	Research limitations by fund source;	Mike Priniski	2/28/99
d.	Draft and circulate program policy clarifying what funds can be spent on substance abuses services.	Aimee Schwartz, Christy Dye, Mike Franczak, Mike Priniski, Theresa Robbens	5/1/99

DUAL DIAGNOSIS INTEGRATION PLAN

Objective 2. Develop expert consensus model for integrated treatment. See Attachment 1		
Although there is consensus in the literature, there is no locally accepted program model for delivery of integrated treatment for co-occurring disorders		
Action	**By Whom**	**By When**
a. Convene an advisory group of key stakeholders;	Christy Dye and Michael Franczak	1/15/99 ✓
b. Conduct an initial knowledge exchange session with local and national experts to identify exemplary practices;	Kenneth Minkoff, M.D. Joel Dvoskin, Ph.D. Robert Drake, M.D *See Attachment 3*	2/10/99- 9/30/99 ✓
c. Identify expected outcomes and corresponding local model;	Advisory Group	3/1/99- 9/30/99 ?
d. Identify barriers to implementing integrated treatment; Policy, funding, clinical practice, screening/assessment and PA/UR;	Advisory Group	2/10/99- 7/1/99 ?
e. Develop plan to overcome barriers, implement and test model.	Advisory Group: A) Barriers B) Implement	 9/30/99 1/1/2000

Objective 3. Evaluate service need and system capacity.			
	Action	By Whom	By When
a.	Estimate number of class members with co-occurring disorders;	HSRI: A) Gap analysis	8/1//99
b.	Based on above model and existing capacity, estimate # of new services/providers to be developed.	HSRI: A) Capacity analysis B)Estimation model	5/15/99 7/2000

Objective 4. Increase number of agencies contracted to work with this population			
	Action	By Whom	By When
a.	Recruit new providers	ValueOptions	10/1/99-2/1/2000
a.	Develop capacity within existing providers	ValueOptions	7/1/99-7/1/2000

?

Objective 5. Develop outcome measures and performance incentives. See Attachment 2			
	Action	By Whom	By When
a.	Develop/publish initial DBHS performance measures set for mental health	Ann Froio	11/1/98 ✓
a.	Convene treatment outcome and performance measure consensus panel;	Christy Dye	1/28/99 ✓
b.	Identify measures of outcome, case mix adjustments and data collection points;	Christy Dye, Consensus Panel, TOPPS Research Team	1/28/99-6/30/99
	(1) Assess need for specialized substance use, abuse, dependence measures		1/28/99-6/30/99 ✓
	(2) Coordinate core measures set with National TOPPS Advisory Panel;		4/15/99 ✓
	(1) Implement revised TOPPS follow-up survey instrument.		8/1/99

Need narrative

c.	Identify measures of system performance, case mix adjustments and data collection sources;	Christy Dye, Consensus Panel, TOPPS Research Team	1/28/99-9/30/99
	(1) coordinate core measures set with National TOPPS Advisory Panel;		4/15/99
	(2) design query structure for MIS monitoring of system indicators;		2/1/99-7/1/99
	(3) recommendations for ALFA collection time frames;		7/1/99
d.	Develop baseline indicator data;	Christy Dye, Consensus Panel, TOPPS Research Team	7/1/99-5/1/2001
	(1) "Norm" MIS indicators quarterly;		7/1/99-5/1/2001
	(2) Field launch of 2-year patient follow-up survey;		6/1/2000
e.	Finalize indicator set with recommendations from Consensus Panel	Christy Dye, Consensus Panel, TOPPS Research Team	6/15/2001

Objective 6. Evaluate ADHS/DBHS Professional Capacity and Need for Technical Assistance

Evaluate ADHS/DBHS capacity to implement the plan, including the number of qualified professionals needed who are experienced in the planning and development of substance abuse services and who are knowledgeable of various federal, state, and private programs relevant to meeting the needs of class members with co-occurring disorders. See Attachment 4.

Action	By Whom	By When
a. Evaluate internal DBHS capacity for implementation plan support in statistical analysis, ongoing best practice analysis, program level expertise.	Christy Dye, Mike Franczak, Ann Froio, Carol Smallwood	2/1/99
a(1). <u>Statistical analysis</u> As of 3/1/99, staff experienced in: i. SPSS/other packages: 4 fte; 2 grant supported ii. Sampling design, follow-up patient interviews: 0 fte; 2 grant supported iii. Analysis of patient interview data: 2 fte; 2 grant supported iv. Analysis of patient MIS record data (CEDAR measures): 0 fte; 0 grant supported	Christy Dye, Mike Franczak, Ann Froio	3/1/99

a(2). <u>Best Practice Analysis</u> As of 3/1/99: i. Staff with Internet lit review capabilities: 10 fte ii. National consultants with expertise in clinical practice: 2 (one-year grant) iii. National consultants with expertise in patient outcomes/system performance: 3 (three-year grant) iv. Assessment of key data trends: QM Committee v. Staff for program design & implementation: 0 fte vi. Staff for RBHA technical assistance/oversight: 0 fte	Christy Dye, Mike Franczak, Ann Froio	3/1/99
a(3). <u>Program Level Expertise</u> As of 3/1/99: i. Management staff with specialized training in dual diagnosis: 2 fte ii. Staff for program design & implementation: 0 fte iii. Staff for RBHA technical assistance/oversight: 0 fte	Christy Dye, Mike Franczak, Ann Froio, Carol Smallwood	3/1/99

b. Evaluate need for outside professional expertise, based on above.	Christy Dye, Mike Franczak, Ann Froio	3/1/99
i. RBHA fte staff designated for this population/program: .25 (Maricopa only)		3/1/99
ii. Ongoing national consultant support: 0 fte		3/1/99
c. Evaluate need/current resources for internal staffing and external support, based on above.		3/1/99
Internal		
i. Staff for program design & implementation: 1 fte required (co-funded position)		3/1/99
ii. Staff for RBHA technical assistance/oversight: 1 fte required (co-funded position)		3/1/99
External Develop Y2002 Budget Request for unfulfilled staff needs, based on above:		5/1/2001
i. 1 fte staff in Pima/Maricopa; .5 fte in NARBHA, PGBHA, Excel		
ii. 2 national consultants for ongoing TA		

ii.	2 national consultants for ongoing technical expertise		5/1/2001

ATTACHMENT I

Integrated Treatment for Adults with Mental Health and Substance Abuse Disorders

CFDA # 93.230

Substance Abuse and Mental Health Services Administration

Submitted By

Michael Franczak, Ph.D., Chief
Christina Dye, Chief
Bureau of Substance Abuse and General Mental Health
Division of Behavioral Health Services
Arizona Department of Health Services
James Allen, MD, MPH, Director

June 16, 1998

ABSTRACT

Integrated treatment for adults with mental health and substance abuse disorders

This proposal is submitted by the Arizona Department of Health Services, Division of Behavioral Health Services, Bureau for Persons With a Serious Mental Illness (ADHS/DBHS/BPSMI) and Bureau for Substance Abuse and General Mental Health, which will serve as the fiscal and coordinating entity. ADHS/DBHS is currently engaged in a series of initiatives surrounding best practices in the treatment of co-existing conditions. Activities to date have included specialized training on exemplary treatment practices among offenders with co-occurring psychiatric and substance abuse disorders and an initiative to develop and refine clinical standards of care for dually-diagnosed adults. Historically, treatment of these conditions has followed a model of sequentially addressing the needs of the client through parallel systems of care. In this model, mental health and substance abuse services are typically provided by separate programs and clinical staff with little sensitivity or orientation to client needs which fall outside of their area of specialization. In addition, treatment frequently takes place in separate facilities and often at separate times in the year. This pattern has progressed undisturbed over time although dual diagnosis is, today, the rule rather than the exception.

The ADHS/DBHS seeks to develop a forum for integrating mental health and substance abuse treatment in a fashion that best serves the needs of dually-diagnosed adults. A considerable body of research points toward integrated service delivery models as contributing to improved patient outcomes. ADHS/DBHS proposes to utilize the grant resources to convene and support expert forums of mental health and substance abuse providers to directly discuss and confront the philosophical and service system barriers that perpetuate the parallel treatment model. Products of the project include models for provider/network subcontracting to improve service delivery and standard of care guidelines addressing such areas of use of psychotropic medications (including methadone), goals of substance abuse treatment for psychiatric clients, use of supportive case management, and the role of relapse prevention and recovery supports in psychiatric care.

The objectives of this project are to generate state consensus and implementation of integrated mental health and substance abuse treatment by: 1) convening an advisory group of key stakeholders on a monthly basis; 2) conducting knowledge exchange sessions with local and national experts in order to identify exemplary practices regarding integrated treatment; 3) using group consensus building methods to identify the local model and barriers to implementing integrated treatment, (4) developing a work plan to overcome the barriers and implement the integrated treatment model, (5) disseminating the results statewide, and (4) monitor implementation and results.

A. Description of Exemplary Practice

The Arizona Department of Health Services, Division of Behavioral Health Services, will initiate a consensus building process to establish statewide key stakeholder support for the implementation of exemplary integrated treatment practices for individuals with co-occurring mental health and substance abuse disorders. Peters and Hills (1997) identified the following key principles in the integrated treatment model: 1) dealing with both disorders as primary, 2) integration of services, 3) individualized programming to address symptom severity and skill deficits, 4) treatment comprehensiveness and flexibility, 5) phased treatment intervention with graduated intensity, 6) treatment continuity, 7) engagement, 8) psychopharmacological interventions when necessary, 9) peer support and self-help groups and 10) reassessment and modification as necessary.

Individuals with co-occurring mental health and substance abuse disorders represent one of the most challenging populations to serve. The Center for the Study of Issues in Public Mental Health (1998) based on a random sample of individuals receiving services in New York State reported that 57% of individuals with a severe mental illness diagnosis also had a diagnosis of substance abuse. This study also reported that the rates for individuals in inpatient settings was considerably greater. The highest prevalence rates are found in the criminal justice system. The GAINS Center (1997) estimates that on any given day 642,500 prison inmates have both a serious mental illness and a co-occurring substance abuse disorder. In addition to the high prevalence of the co-occurring disorder, these individuals generally do not respond as well to standard treatments (Bowers, Mazoure, Nelson and Jatlow, 1990), are hospitalized more frequently (Hills, 1994), are more frequently homeless (Osher, Drake, Noordsy and Teague 1994), have a higher frequency of violence (Steadman, et. al., 1998 and Monahan, 1995) and are incarcerated more often (Abram and Teplin, 1991) than individuals who have either single diagnosis. One of the most compelling reasons for improving treatment to this population was provided by Hser, Anglin & Powers (1993). During the course of a 24 year study with substance abuse disorders, they discovered that even with intermittent treatment only 19% had attained stable abstinence. The most chilling finding was that 28% of their original sample were deceased.

The State of Arizona currently has 24,000 individuals with serious mental illness enrolled in the publicly funded behavioral health system. Using the most conservative estimate, approximately 14,000 individuals in this group are likely to also have a substance use or abuse disorder. Fifty six percent of this group are females and 24% of the population are minorities, the largest percentage being Hispanic or African American. There is also a significant number of Native Americans in this group. Only 5% of the population have incomes over $10,000 per year. A significant number of these individuals are unemployed, homeless and involved with the criminal justice system. For the purposes of this project the target group will be individuals with serious mental illness and substance use or abuse disorders. The priority population will include individuals from minority groups, individuals involved in the criminal justice system and women. Additional target groups will be included after the process is implemented, tested and refined statewide.

Currently in Arizona, most treatment programs for these individuals are organized in a sequential fashion in which the individual must complete the treatment for one diagnosis before they can enroll in treatment for other diagnoses. Osher and Kofoed (1989) refer to this model as "ping-pong" therapy. The extended sequential treatment approach is contrary to what has been discovered regarding the treatment compliance of this population. Research has shown that individuals with co-occurring disorders are more likely to terminate treatment prematurely and to attend treatment less consistently (Hall, Popkin, DeVaul and Stickney, 1977). Individuals with co-occurring disorders are less likely to stay the course of extended sequential treatment (Osher and Drake, 1996). An alternative to sequential treatment is the parallel treatment model in which both treatments are offered simultaneously by different providers. Arizona has a number of programs that fit the parallel treatment model. While the parallel model offers improvements over the sequential model, there are a number of difficulties which are inherent with multiple uncoordinated treatment providers (Weiss and Najavits,1998). Services for this population are divided by funding sources, admission criteria, treatment methods and philosophies and staff training and qualifications (Sciacca, 1991). Both the sequential and parallel approach to treatment retains the bulk of these problems.

Integrated treatment models have been proposed by Minkoff (1989) and Minkoff and Drake (1991) which provides for the simultaneous treatment of both disorders within the same treatment setting. The consensus at the 1995 dual-diagnosis conference as reported in Mental Health Weekly (1995) was that integrated treatment which addressed both issues simultaneously was superior to separate treatment for each condition. While there has been considerable debate primarily within the substance abuse provider community regarding the reported superiority of integrated treatment approaches, the majority of professionals endorse this approach (Mental Health Weekly, 1998).

After a thorough examination of the available treatment models, the Arizona stakeholders have determined that integrated treatment represents "best practice" for the following reasons: 1) The vast majority of the professional literature reports that the results of integrated treatment are superior to those of sequential or parallel approaches, 2) these findings have been replicated in numerous settings and states and have been generalized from inpatient to community settings, and 3) behavioral health professional organizations have endorsed the model in their publications and at conferences.

Drake, Rosenberg, and Muesser (1966) in a review of the literature have concluded that the outcomes achieved by integrated treatment are superior to those achieved by either sequential or parallel treatment. Peters and Hills (1997) reported that the best chance for sustained remission for individuals with co-occurring disorders is provided by an integrated treatment approach. They further note that the desirable features of integrated treatment include 1) assertive outreach and intensive case management, 2) a comprehensive range of services to accommodate individuals at varying levels of severity, 3) an emphasis on engaging and motivating the person to commit to treatment, 4) conceptualizing people passing through stages or phases of treatment, 5) modification of pharmacological approaches and 5) and ongoing assessment and treatment plan modification.

The outcomes obtained from integrated treatment have been far superior to those obtained by either

sequential or parallel methods. Mueser, Drake and Miles (1997) reported that the weight of the evidence for 30 studies of integrated treatment is overwhelmingly positive. Jerrell and Ridgely (1995) studied three models of integrated treatment and discovered improvements in work, independent living social relationships, satisfaction, a reduction in psychiatric symptoms and decreased use of emergency room visits. Bond (1989) reported decreased hospitalization rate for individuals enrolled in an integrated treatment model. Kofoed, Kania, Walsh and Atkinson (1986) and Hellerstein and Meehan (1987) also reported significant reduction in the rates of hospital utilization. Ries and Ellingson (1989) reported a increase abstinence for inpatients enrolled in an integrated treatment approach. The most dramatic finding was presented by Drake, McHugh and Noordsy (1993) in which 60% of the patient who received integrated treatment remained abstinent during a four year follow-up.

The integrated treatment approach has been replicated successfully in numerous settings. Sciacca reported the implemented a successful integrated treatment approach in New York State. Barr (1994) implemented integrated treatment in Los Angeles, California. Minkoff (1989) has replicated his model which was developed in an inpatient setting to other community settings and systems in Massachusetts. Ridgely, Lambert, Goodman, Chichester and Ralph implemented a successful integrated model in Cumberland County, Maine in 1998. Muesser, Drake and Miles (1997) report the successful implementation of an integrated approach in New Hampshire. Dr. Minkoff has also provided training to the State of Illinois as part of their attempt to implement an integrated model.

Presentations and workshops have been held regarding the integrated treatment model at the American Psychiatric Association and the American Psychological Association Annual Conventions and at special conferences focused on the treatment of individuals with co-occurring disorders. The GAINS Center as part of a technical assistance grant has sponsored training in integrated treatment in numerous states and also provides a variety of educational materials on the subject. Consumer and family organizations such as National Alliance for the mentally Ill are providing literature on the subject of integrated treatment to their membership. The Center for Substance Abuse Treatment included the integrated treatment model in the Assessment and Treatment of Coexisting Mental Illness and Alcohol and Other Drug Abuse Treatment Improvement Protocol (CSAT, 1994).

While integrated treatment approaches have many elements in common, there are also number of cases in which the models emphasize different elements. Due to the number of necessary elements and the variation which exists within current models, the implementation of an integrated model in Arizona will not simply be a "cookie-cutter" process. The integrated model proposed by Minkoff (1989) which was originally developed in an inpatient setting has the following components: 1) Acute stabilization, 2) engagement, 3) prolonged stabilization, and 4) rehabilitation. Mueser, Drake and Miles (1997) describe the following common components of most integrated models: 1) simultaneous treatment of both disorders by the same person, team or organization, 2) case management and group interventions, 3) assertive outreach, 4) education, 5) focus on motivational aspects of treatment, 6) focus on the long-term perspective. They further indicate that integrated models differ on the degree of emphasis that is placed on the following components: 1) use of behavioral strategies to reduce urges, 2) working with patient's families, and 3) employing a step-

wise or graduated approach.

Another element of integrated treatment which is present in most models is that the treatment modality must be present in all components of the continuum of care. Since individuals will present with varying levels of severity, the elements of integrated treatment must be available in inpatient settings, acute residential, therapeutic communities, club houses, drop in centers, peer and family support groups, supported housing, and vocational services. Individuals may enter the system at various points and as functioning level improves, many will advance to additional program activities which must be capable of continuing services for both mental health and substance abuse issues. It is therefore necessary to educate a wide variety of professional disciplines, family members and support groups in the integrated model.

It is for the above mentioned issues that ADHS/BHS has chosen to seek consultation from national and local experts. Drs. Minkoff and Drake have both implemented integrated models in a variety of settings. Although there are common elements to their models, there are also distinctions which may prove critical to the Arizona system. Dr. Dvoskin has had extensive experience in implementing systems of care and will focus on the naturalization of the model to the Arizona system and culture.

B. Project Impact/Feasibility

The Arizona Department of Health, Division of Behavioral Health is the central authority for providing both mental health and substance abuse services throughout the publicly funded behavioral health system. Having both services rest within the same agency makes the integration of services more likely. There is also widespread support and commitment from key stakeholders in Arizona to participate in discussions intended to lead to consensus on integrated mental health and substance abuse treatment. Although there are some areas of disagreement on the exact format for integrated treatment and what is considered best practice, all of the key stakeholder who have been contacted by the applicant have expressed a willingness to seek consensus state wide and to follow through by implementing the group decision.

As a result of informal discussions in preparation for this application, representatives of the following organizations and agencies have agreed to participate in the integrated treatment consensus building project. Support has been obtained from the Consumer Advisory Board, the Arizona Department of Health Services, the Council for Offenders with Mental Impairments, the Association of Behavioral Health Providers which includes representatives from the majority of mental health and substance abuse providers, the Behavioral Health Planning Council, the Mental Health Association of Arizona, the Arizona Alliance for the Mentally Ill, The Arizona Center for Disability Law & Patients Rights, the Office of the Monitor, all five of the Arizona Regional Behavioral Health Authorities, as well as individual consumers, professionals, and family members.

The development of stakeholder support began in February 1998 as a result of a three-day workshop that was conducted by the GAINS Center from Delmar, New York. The workshop was conducted

as part of their technical assistance mission in association with a SAMHSA Grant focused on jail diversion programs. GAINS Center consultants for the workshop included Patty Griffin, Ph.D., Fred Osher, M.D., and Roger Peters, Ph.D. The initial day of training was provided by Drs. Osher and Peters and consisted of an overview of "best practices" related to co-occurring disorders. The second and third days of training, facilitated by Drs. Griffin and Peters, focused on cross-training exercises designed to assist workshop participants with applying information and treatment strategies discussed during the first day of training. Approximately 125 people primarily from Maricopa County participated in the training including community mental health and substance abuse administrators, service providers, jail mental health staff, behavioral health care administrators, staff from the local housing authority and consumers. The second workshop was conducted for staff from the entire state on April 15-17, 1998 in Tucson, Arizona. GAINS Center consultants included Roger Peters, Ph.D., Joel Dvoskin, Ph.D. and Roger Weiss, M.D. The format was similar to the previous workshop. The first day of training consisted of an overview of clinical topics related to "best practices" in co-occurring disorders, and the second and third days of training focused on applications. Approximately 100 persons participated in the training, consisting of teams of individuals from each of the five RBHAs.

As a result of these two workshops, a state wide consensus was reached that the current process in Arizona does not meet the needs of individuals with co-occurring mental health and substance abuse diagnoses. While many organizations provide a variety of services for this group, they are not producing the outcomes that are desired. Many clients leave the programs before they have successfully completed the protocol and show up later in other parts of the system repeating the same pattern of treatment resistance. Many organizations were very frustrated with each other due to the fact that they felt that the enrollment and eligibility criteria prohibited coordinated services. Mental health providers felt that most substance abuse providers discouraged the use of psychotropic medications which were essential for the reduction of psychiatric symptoms. Conversely, substance abuse providers derided the mental health providers refusal of clients who were not "clean and sober".

After considerable debate and discussion, the group achieved consensus that the current sequential and parallel treatment models in Arizona were at best, marginally effective. They committed to working together the resolve the current state of affairs. This grant application is largely the result of the enthusiasm to improve services to this population that was generated by the organizations that attended the two workshops.

In addition to the key stakeholders and work group, ADHS/BHS the applicant will conduct additional information forums for consumers, family members, and staff describing the Integrated Mental Health and Substance Abuse Treatment Model and the progress of the work group (Sechrest, Backer, Rogers, Campbell, and Grady 1994). The project will produce and distribute comprehensive information packets to consumers and others desiring detailed information. Information will be contained in the Behavioral Health Services Weekly Newsletter and other published reports.

The Integrated Treatment Project (ITP) will solicit consultation and technical assistance from other

states and agencies which have implemented integrated treatment and other key stakeholders on the efficacy of its efforts to identify and overcome barriers to the establishment of state wide consensus on the implementation of Integrated Mental Health and Substance Abuse Treatment. The issues that have been reported as potential barriers will be identified and discussed during the information forums. Potential solutions to these barriers which may be suggested by the participants will be recorded for consideration during the work group planning and implementation process.

While the actual work group will determine specific barriers to implementing the integrated treatment model, a number have already been noted by the conference attendees and the other groups that were contacted. The most notable barriers were the following: 1) separate eligibility criteria, 2) staff knowledge, 3) funding streams, 4) constricted agency missions, 5) contracting processes, 6) data system shortcomings, and 7) lack of agencies willing to work with this population. None of the barriers that have been identified were considered impenetrable. Eligibility and funding decisions are controlled by the Arizona Department of Health Services, Division of Behavioral Health and can be reconsidered. Staff knowledge can be enhanced by additional cross-training. Constricted agency missions, lack of appropriate providers and contract issues are issues that have been identified by providers as being adjustable. Ultimately it will be up to the Integrated Treatment Project (ITP) work group to identify the specific actions that will be necessary to remove all of the barriers. Many of the aforementioned barriers have already been addressed in other sites implementing this model and it is anticipated that the consultants, Drs. Minkoff, Drake and Dvoskin will provide invaluable assistance in methods to overcome the obstacles.

It is anticipated that there will be no significant adaptations to the methods used to implement Integrated Mental Health and Substance Abuse Treatment Model as established in other states. Nevertheless, particular attention will be focused on how the proposal is received and responded to by the Arizona managed care behavioral health system provider community. Managed care systems utilize practices such as preferred providers, utilization review, prior authorization and provider networks which may pose special problems for the implementation of Integrated Mental Health and Substance Abuse Treatment Model. By addressing these particular issues, the Integrated Treatment Project will provide valuable information for other states as they also begin to implement Integrated Mental Health and Substance Abuse Treatment Models in managed care settings. Arizona must also consider issues with respect to urban, rural and frontier areas. The model that is developed will need to be one that can applied in each of these settings.

The impact of these activities on the treatment provided to individuals with co-occurring mental health and substance abuse will result in improved treatment outcomes, greater consumer and family satisfaction with behavioral health services, reduced involvement in the criminal justice system, reduced homelessness and improved functioning.

ADHS/DBHS will provide in-kind resources to supplement the grant award. ADHS/DBHS staff will coordinate & schedule the statewide work groups and disseminate the information developed by the work group to other stakeholders. ADHS staff will assist in the facilitation of group and coordinate activities of the key stakeholders with respect to the projects goals and objectives. It is anticipated

that once consensus has been established on the Integrated Mental Health and Substance Abuse Treatment Model, the on-going task of providing information and guidance to consumers, family members, service professionals, and others will be maintained by the Arizona Department of Health Services, Division of Behavioral Health Services and the Regional Behavioral Health Authorities. Funding will be directly expended from the state level as well as indirectly through the expenditures of the Regional Behavioral Health Authorities. The State and the Regional Behavioral Health Authorities will provide in-kind match funding by dedicating staff time and travel expenses to the work group. All funds to provide integrated treatment will be coordinated and/or provided by the Arizona Department of Health, Division of Behavioral Health.

C. Project Approach/Plans

During the application process, the intent and scope of the project was explained to representatives of key stakeholders. Key stakeholders reviewed and commented on drafts of the application, including the proposed method for implementing the exemplary practice. An ADHS/DBHS staff person, who is also a consumer, was a key participant in the preparation of the application.

A 9 Step Problem Solving and Group Consensus process will be utilized to establish a statewide consensus for the establishment and implementation of an integrated treatment model throughout the State of Arizona. The expected outcomes are: 1) the identification of a formalized model of integrated treatment model which will include "best practices" using both local and national experts, 2) a comparison of the "best practice" model and the current treatment models, 3) the identification of barriers to implementing "best practices", 4) the plans and methods to overcome the identified barriers, 4) an implementation plan and 5) a validation procedure.

The 9 Step Problem Solving and Group Consensus process is a formalized method of group decision making that facilitates drawing on the knowledge of experts, providers, policy makers, individual consumers, family members, advocacy groups, treatment staff, and other key stakeholders. The 9 Step Process has been successfully used by ADHS/DBHS as a team building and problem solving activity (Arizona, 1996). A trained group facilitator will be responsible for conducting the process. The diverse stakeholders who will be involved in the process all bring vested interests in the implementation of mental health and substance abuse treatment and all bring common and unique experiences to the table. Group members will be guided by the group facilitator to provide information about their perceptions of and disposition towards integrated treatment.

The composition of the group will be evenly distributed throughout the five regional behavioral health authorities geographic areas. The group will designate one representative and an alternate to attend statewide group which will produce a final consensus. Each group will be facilitated by the same person with assistance from ADHS/DBHS and Regional Behavioral Health Authority staff. At least one representative from the ADHS/DBHS Consumer Advisory Board will attend each meeting. Meetings will occur throughout the state in order to reduce the travel burden for rural areas.

Action grant funding will provide Arizona the opportunity to 1) educate the stakeholder group on

the "best practices" for integrated treatment using both local and national experts, 2) support ongoing monthly meetings by providing stipends to consumers, families and small agencies, 3) provide ongoing support to evaluate the integrity of the group process and 4) to develop and implement the "best practice" model that is developed.

A. The 9-Step Problem Solving and Consensus Building Process

The 9 steps are divided into two (2) phases:

Planning Phase (Steps 1 through 6): begins with the project and work group selection, through the development of recommendations and implementation planning. Many aspects of Steps 1-2 have already been implemented in the preparation of the grant application.

Implementation Phase (Steps 7 through 9): executing the implementation plans, inclusive of testing the plan and measuring it's impact.

Planning Phase:
Step 1: Identify

This step of the problem-solving and consensus process was implemented as part of the grant application process. The issue of integrated treatment was reviewed with ADHS/BHS management staff, key stakeholders from the provider network, consumers and families and other local and state government agencies. A unanimous decision was reached to apply for grant funds to pursue this statewide objective.

Step 1 Activities:

1. The project has full support of management at the ADHS/BHS, Regional Behavioral Health Authorities, providers, advocates, consumers and family levels .
2. The process targeted for improvement has direct impact on the organization's (a) external customers, (b) internal customers, (c) stakeholders, and (d) other citizens of Arizona.
3. The process or project is related to: (a) key business issues, (b) Strategic Plan goals and objectives, and the (c) mission of organization.
4. Infrastructure is in place in the organization to support the process.
5. The scope of the project is clearly defined.
6. The project has an achievable, measurable goals that has been studied and approved by management.
7. Potential financial resources (the Community Action Grant and state in-kind resources) have been identified.
8. The project represents a clearly defined process that can have easily identifiable starting and ending points, including implementation and validation.
9. The project was identified from one or more of the following sources: (a) employee suggestions. (b) annual employee survey. (c) customer survey, (SWOT) analysis. (e) Strategic Plan goals and objectives, (f) input from critical stakeholders, (g) recommendations from outside the organization.

The Step 1 deliverables include:

- The completed grant application.

- Identification of stakeholders.
- Identification of potential work group.
- Preliminary problem statement, addressing:
    - WHO is affected?
    - WHAT is involved?
    - WHEN is it happening?
    - WHERE is it happening?
    - HOW much/many/often is it happening?
- Identification of "best practice".
- Identification and contacts with local and national experts.

Step 2: Form the Work Group and Scope the Project

Group members will be selected or asked to volunteer based on their understanding of and involvement in the process under review and involvement in the new process. The group leader and facilitator will be selected. While some members of the group have already been identified, additional members will be recruited from the stakeholder groups.

Step 2 Activities:

1. Appropriate members have volunteered/been selected for the work group.
2. Group members are trained and knowledgeable of the task we are undertaking.
3. The work group has a clearly defined mission and scope.
4. A communication plan has been developed to keep all key stakeholders informed of the project's progress.
5. A process has been defined to resolve group issues, in the event of an impasse.
6. Meeting agenda and meeting minute templates have been agreed upon to communicate meeting activities.
7. A meeting evaluation tool has been agreed upon to assess the group's "health" following each team meeting.

Step 2 deliverables include:

- full work group is established
- clarification of group roles and responsibilities
- code of conduct addressing group rules/norms
- high-level work plan/action plan
- communication plan to keep the work group and stakeholders informed
- issue resolution process for resolving group issues
- meeting agenda and meeting minutes templates for announcing and recording group activities and events
- meeting evaluation tool to gauge the health of the work group

Step 3: Develop Vision of "To Be" Process

The objective is to select an improvement strategy for the group to pursue. At this stage the local and national experts will be called upon to identify the "best practice" model. The model will be described in detail.

Step 3 Activities:

1. Experts present a detailed "best practice" model.
2. A flowchart of the desired "To Be" process is completed.
3. Project/process goals and objectives have been revisited and performance measures have been established.
4. Qualitative and quantitative benefits of the recommendations have been identified.
5. Costs to implement recommendations have been estimated.
6. Possible consequences/impact of group recommendations on other areas of the organization have been noted and efforts to avoid negative effects have been taken.

Step 3 deliverables include:

- "best practice" model is developed
- criteria for each component is defined
- process map or flowchart of "To Be" process
- project performance measures and objectives
- "To Be" benefits to the organization
- estimated cost of proposed recommendations
- presentation/executive summary

Step 4: Analyze Current "As Is" Process

This step represents the group's analysis of the current process under review. Baseline performance measures are established as an indicator of "as is" process performance.

Step 4 Activities

1. Process "inputs" and "outputs" were identified.
2. Customer and stakeholders of the process under review were identified.
3. A process map or flowchart was completed to identify all activities in the process.
4. "Other" analysis tools, as appropriate, are used to capture baseline measurements (number of individuals served, outcomes, per member/per month costs).
5. The gap between what the group wants or desires and what the group is getting is determined.
6. A refined problem statement, reflecting further areas(s) of opportunity following gap analysis, was identified.

Step 4 deliverables include:

- process map or flowchart of "As Is" process
- inputs, outputs and outcomes of the process
- customer/stakeholder analysis
- baseline customer requirements of the process and output
- baseline measurements using run charts, parieto diagrams, histograms, scatter diagrams, control charts, check sheets, as applicable
- gap analysis
- refined problem statement

Step 5: Identify Barriers to the Implementation of the "To Be" Process

Obstacles and barriers to implementing the "to be " process are identified to pave a pathway toward the desired solutions and results.

Step 5 Activities:

1. An analysis of the "To Be" process is conducted with specific barriers identified.
2. Obstacles and barriers with the greatest impact were identified.
3. Span of control is identified.
4. Stakeholders associated with each barrier are identified.

Step 5 deliverables include:

- Flow chart indicating each barrier and source.
- Type of barrier is identified (perception, financial, staff knowledge, etc.)

Step 6: Identify Methods to Overcome Barriers to Implementation

The obstacles and barriers to implementation identified in Step 5 are examined and methods to overcome each barrier are identified.

Step 6 Activities:

1. Methods to overcome each obstacle or barrier are identified.
2. Accountable parties or sub-work groups are identified for each obstacle or barrier.
3. Time lines are established for work on each barrier.
4. A comprehensive work plan is developed.

when

Step 6 deliverables include:

- A work plan with accountable parties and time lines is developed.
- Initial work plan is reviewed and adjusted.
- Sub work-groups may be established.

Implementation Phase

Step 7: Develop Plan and Pilot Proposed Solutions

A plan to implement the "To Be" process is developed. Before implementation of the "To Be" recommendations on a grand scale, a pilot test of the new process proposal to test its effectiveness is developed. The pilot will include time frame for implementation and validation, as well as identifying the who, what, where, when and how the elements will be rolled out.

Step 7: Activities

1. Pilot implementation steps of the "To Be" have been outlined.
2. Pilot area/population subset has been identified to test new process.
3. Due dates and milestones have been targeted.
4. Methods for monitoring pilot progress have been put in place.
5. Training/guidelines have been afforded to everyone who will be involved in the pilot.

Step 7: deliverables include:

- pilot plan (*who* is involved? *what* is involved? *where* is it involved?)
- pilot milestone and due dates
- performance measures
- training program/ guidelines to educate all be involved in the pilot

Step 8: Refine and Implement Successful Solutions

Once the recommendations have been piloted, the group needs to evaluate implementation status as compared to group performance measures and objectives. Upon review by the group, the decision to modify and refine or to pursue onward, as is, must be made prior to full implementation of recommendations.

Step 8: Activities:

1. The prescribed implementation steps were followed (everyone did what they said they would do).
2. Initial barriers identified were removed.
3. Performance objectives were met/exceed..no gap between the "As Is" and "To Be" desired state exists.
4. Modifications were or were not required prior to full-scale implementation.

Step 8: deliverables include:

- performance measurement documentation (i.e., check sheet, parieto chart, run chart, histogram, control chart, scatter diagram, survey, etc.)
- gap analysis, to note if further modifications need to be pursued
- implementation action plan (once no further modifications are required)
- presentation/executive summary

when

Step 9: Measure Progress and Hold Gains

This step presents the group's work plan to institutionalize the proposed process throughout the state. The plan will be in sufficient detail so everyone understands the time elements to complete the implementation, major action areas and individual responsibilities.

Step 9: Activities:

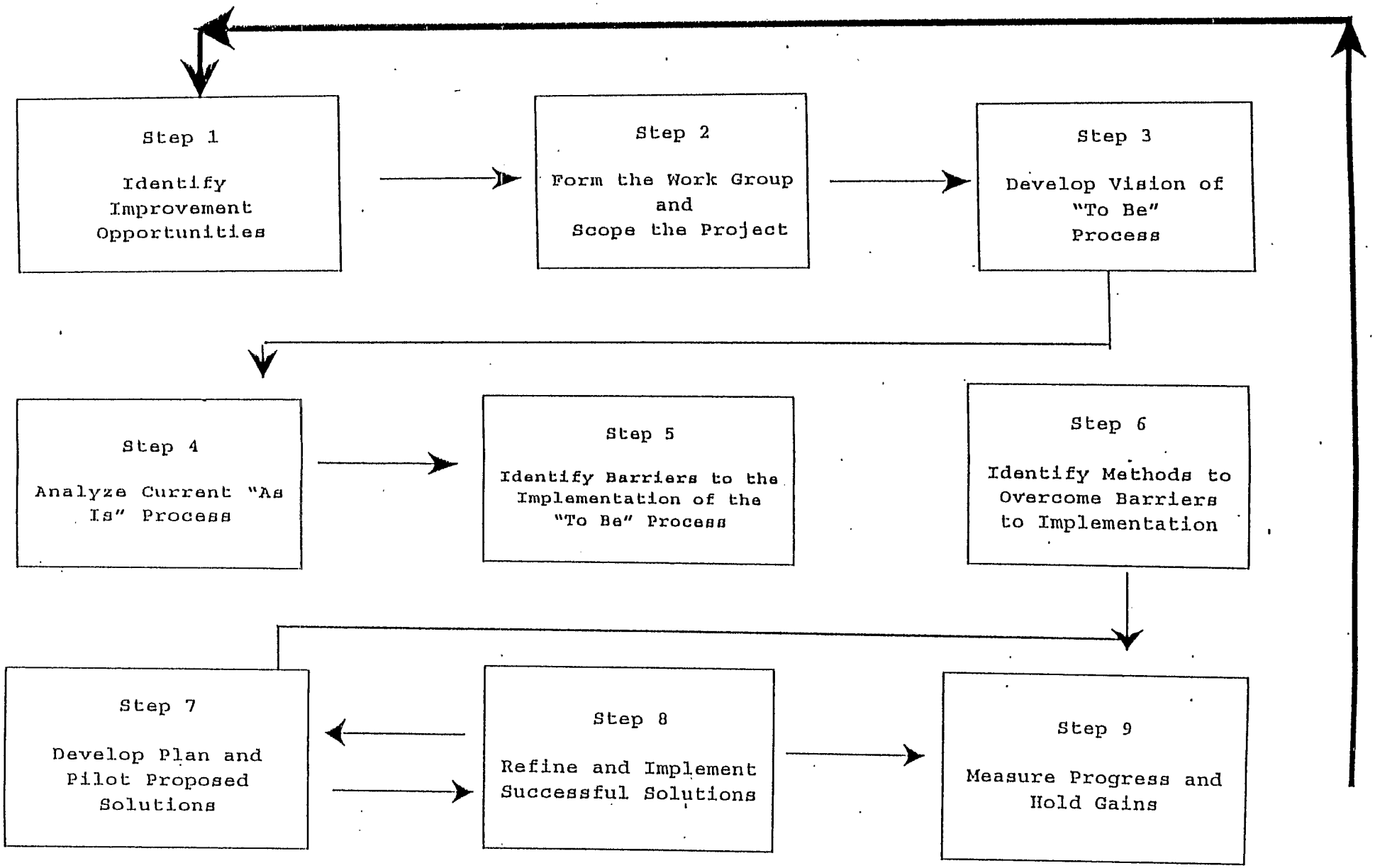
1. Steps have been proposed to assure continued use of the process.
2. The appropriate people have been identified to implement and monitor the process.
3. Indicators/performance measures have been implemented to signal the response to regroup and rethink the process, should that need arise.
4. Methodology to communicate/display the efficiency and effectiveness of the process has been chosen.
5. Actual project costs and project results, far, were recorded.

Step 9: deliverables include:

- operating/procedure manual
- performance measurement system, goals and objectives
- communication plan
- presentation/executive summary

The major project activities listed below will be implemented to accomplish the project goals and objectives. Specific timelines will be determined during the planning period prior to the official start date of the project following consultation with the Integrated Treatment Work Group. This plan assumes notification of award on or about September 15, 1998. If the notification date is substantially earlier or later, there will be a 15 to 20 day pre-planning period before official implementation of project. The hypothetical time line for the 9 Step process is described in the following documents. The steps in the 9 Step Process may be modified based on the work group discussion. In some cases the "as is" process is analyzed prior to the "to be" process. In addition, the time which is allocated to each step in the process may be adjusted if the work group's progress on any of the steps is either delayed or more rapid than anticipated.

9-Step Problem Solving and Consensus Building Process



Work Plan

Meeting Dates	Location	Activities	Consultants	Objectives
September 15, 1998		Notified of Grant Award		Notify participants/finalize contracts.
October 1, 1998	Phoenix	Official Project Start Date		
October 1, 1998	Phoenix	Step 1-Identify		Work Group is Finalized/First Meeting Scheduled
November 13, 1998	Phoenix	Step 2-Scope	JD	First group Meeting/ Roles &Responsibilities defined
December 11-12 1998	Tucson	Step 3-"To Be"	KM /BD/JD	"Best Practice" model training.
January 8-9 1999	Flagstaff	Step 3-"To Be"	KM/BD/JD	"Best Practice" model developed.
February 9-10 1999	Phoenix	Step 3-"To Be"	KM/BD/JD	"Best Practice" model finalized.
March 12-13 1999	Phoenix	Step 3 &4 Mid Point Opinion Survey Data collection and analysis Summary report reviewed with group	KM/ BD/JD	Current model is described and analyzed.
April 14, 1999	Phoenix	Step 4-"As Is"	JD	"As Is" practice flow chart is developed.
May 12, 1999	Tucson	Step 5-Barriers	JD	Barriers to 'best practice model" are identified.
June 14, 1999	Flagstaff	Step 5-Barriers	JD	Barrier and opportunities are identified.
July 11, 1999	Phoenix	Step 5 & 6-Method	JD	Methods to overcome barriers are identified.
August 14-15 1999	Tucson	Step 6 & 7-Method	KM/BD/JD.	Methods are finalized.
September 15,1999	Tucson	Step 7-Plan	JD	Implementation plan is developed
October 13-14 1999	Phoenix	Step 7 End of Project Group Survey	KM/BD/JD	Implementation plan is finalized.

Key Indicators to be used to determine the degree to which project objectives are being met. The following project management activities will occur: 1) bench marking milestones: 2) weekly status meetings at ADHS/BHS between the Project Directors, 3) monthly oversight meetings and 4) quarterly project audits, which will focus on the management of the project, its methodology and procedures, records, project properties, budgets and expenditures. The audit reports will concentrate on the current status of the project, future status of crucial tasks, critical management issues, risk assessment, information pertinent to other projects and limitations of the audit (e.g., assumptions or limitations affecting the data, etc.).

The Project will require a laptop computer and an LCD computer projector to display group decisions, progress charts and relationships between "as is" and "to be" models. Since the meetings will be held throughout the state, portable equipment will be required. The Arizona Department of Health Services and the University of Arizona will provide software for the presentations and data analysis. ADHS will provide printing and information packet materials. Administrative and clerical support will be provided by the Arizona Department of Health Services, Division of Behavioral Health Services and the University of Arizona.

D. Project Plan For Cultural Competency And Diversity

The ADHS/DBHS has made a commitment to achieve and maintain cultural competency and diversity in its programs and services. These issues have been recognized and are being addressed by the Arizona Department of Health Services/Division of Behavioral Health Services through its five year plan for Cultural Competency In the Administration and Delivery of Behavioral Health Services (1995). Specific efforts will be made to insure that minority stakeholders fully participate in the consensus building process. As previously mentioned, minority groups, individuals who are incarcerated and women will be targeted as priority populations.

The work group will be comprised of consumers, family members, and provider staff in proximate proportions to the demographic composition of the state. The Integrated Treatment Project will insure that stakeholder participation reflects the demographic composition of the target population and the community at large. Support will be specifically solicited from key provider organizations whose membership is predominantly comprised of Hispanic, African-American, and Native American individuals. In addition, key stakeholders will be invited to participate in the group process that will include the Intertribal Council of Arizona, Chicanos Por La Causa, and the Arizona Urban League. We have also obtained a commitment from staff from the Women's Network (Marilee Dal Pra) to participate and serve as a consultant to ensure the product is gender as well as culturally sensitive. Also, consumer and family organizations, the Arizona Behavioral Health Planning Council, the Consumer Advisory Board, and the Mental Health Association will be among the various groups invited to participate in the group process. These groups include wide diversity in the areas of gender, culture, age and language. Materials that are developed as a result of this project will be translated into Spanish and will be made available to all relevant stakeholders.

E. Evaluation Design And Analysis Plan

The purpose of the evaluation design of the proposed project is to provide both formative and summative information regarding the implementation process and the impact/outcomes of the proposed project. Specifically, we have developed our evaluation design around two primary objectives:

Evaluation Objective 1: To compile and evaluate information that demonstrates that the proposed project has been implemented as proposed and to identify and justify and slippages or deviations in implementation.

Evaluation Objective 1 Methodology: Predominantly, the source of information for this objective will be project-related correspondence and materials. Utilizing the GANTT charts developed for this proposal, we will track the actual implementation of the project against proposed actions and timelines. Copies of all project-related correspondence and products, meeting agendas and minutes will be provided to the evaluation team for review and synthesis. Additionally, quarterly interviews will be conducted with co-Project Directors Dye and Franczak to review project activities of the preceding quarter, identifying specific barriers and successes in implementation, along with slippages and advances in project completion. These interviews will be open-ended allowing for semi-structured reviews of major project achievements and outcomes.

Finally, we will utilize a participant observation approach to evaluating the quality and extent of consensus building. Specifically, a member of the evaluation team will become a regular member of the proposed monthly stakeholder meetings and will also attend all knowledge exchange sessions. This individual will attend all stakeholder meetings and conduct ethnographic observations of these meetings. Utilizing standard field note procedures, the evaluator will maintain ongoing open-ended observations of the meetings. In particular, a number of key thematic areas of observation will be noted, including:

- The number of participants attending each meeting and their personological characteristics (ethnicity, gender, consumer, consumer-supporter, provider)
- The overall tone and tenor of the meetings (open dialogue, controlling, agenda-based, open-ended)
- The nature, direction, and frequency of interactions among and between the stakeholders

As a result of these ongoing observations, the evaluator will begin to synthesize observations across meetings and begin to provide a more comprehensive assessment of the process and nature by which the group begins to form around common issues and builds consensus around specific action planning activities. The results of these observations will be maintained throughout the duration of the project and will be compiled into a single summative report at the completion of the Year 1.

Evaluation Objective 2: To assess the efficacy of the proposed consensus building process.

Evaluation Objective 2 Methodology: A formalized 9-step process of problem identification and consensus building has been proposed for the project. The process is developed upon a number of key assumptions. These include the following:

- the individuals participating in the process are representative of the key stakeholders affecting and affected by, the issue under study;
- the process of consensus building allows for and promotes the meaningful participation by each of the diverse stakeholders;
- the individuals participating in the process are provided appropriate and sufficient information to identify best practice, to identify the barriers to best practice, and to identify reasonable and appropriate solutions for overcoming these identified barriers;
- the individuals participating in the process are adequately empowered by their respective

- stakeholder groups to represent their groups' perspectives/interests and to commit their groups to specific action.

In order to test these assumptions, we will utilize both quantitative and qualitative approaches.

First, a meeting evaluation questionnaire will be developed, pilot-tested and implemented prior to the first formal meeting of the stakeholders. The purpose of this meeting evaluation questionnaire will be to compile immediate feedback from the stakeholder participants regarding the effectiveness of each meeting and to identify possible actions for improving the effectiveness of future stakeholder meetings. This brief questionnaire will be distributed and collected prior to the end of each meeting by a member of the evaluation team. The results of these questionnaires will be compiled and distributed to the stakeholders prior to the next scheduled meeting of the stakeholder group, allowing the group to make alterations and corrections in the structure and function of their subsequent meetings.

Second, a small random sampling of the stakeholders will be contacted by telephone by a member of the evaluation team each quarter for an open-ended qualitative interview (approximately 2-3 interviews per quarter). The purpose of these interviews will be to explore stakeholders' perspectives on a number of critical dimensions of the consensus building process including:

- the degree of empowerment and control experienced by the stakeholders in affecting the consensus building process;
- the extent to which the consensus building process is attending to age, cultural, language, and gender issues;
- the extent to which the consensus building process provides for the meaningful involvement of consumers and family members in the decision-making process;
- the quality and extent of orientation, training and consultation provided to the stakeholders;
- the extent to which the consensus building process incorporates achievable and realistic elements of systems change that are attentive to local system barriers.

These telephone interviews will be approximately one hour each in duration with field noting occurring throughout the interview. Immediately following each interview, the interviewer will develop a summary report of the interview, building upon information from previous interviews. In this manner, the interviewer will identify common themes to each of the dimensions listed previously, and attempt to build a typology of over-arching themes for describing the effectiveness of the consensus building process. The results of these interviews will be maintained by the evaluation team and will synthesized into a final, summative evaluation report at the completion of Year 1.

Finally, in order to assess the effectiveness of the proposed knowledge exchange sessions of this project, we will disseminate and collect participant profile questionnaires and training evaluation questionnaires at all knowledge exchange sessions. These brief questionnaires have been extensively utilized by the Community Rehabilitation Division in other training and technical assistance projects and show good reliability and validity. The Participant Profile questionnaire solicits basic information on the personological characteristics of the participants, including their age, gender, ethnicity, and professional status (e.g., consumer, family member, service provider, administrator, etc.). The training Evaluation questionnaire solicits information regarding the participant's satisfaction with the training/information provided along a number of dimensions, including the

organization of the material/presentation, the usefulness of the material, and the extent to which the material met the informational needs of the participants. This questionnaire also allows the respondents to provide qualitative feedback regarding specific positive and negative elements of the training/information. Data from the Participant Profiles and Training Satisfaction questionnaires will be compiled on Quarterly Basis and submitted to co-Project Directors Dye and Franczak.

The evaluation of this project will be conducted by the Community Rehabilitation Division, at the University of Arizona Health Sciences Center. The project leader for this evaluation will be Dr. Michael S. Shafer, Research Associate Professor in the Department of Family & Community Medicine. Dr. Shafer has served as PI for numerous CMHS and DOE grants and has also collaborated with ADHS on numerous initiatives.

F. Management Plan And Staffing

Michael Franczak, Ph.D., Chief, ADHS/BPSMI and Christina Dye, Chief, Bureau for Substance Abuse and General Mental Health will serve as the Project Directors and will be responsible for ADHS/BPSMI coordination with the major key stakeholders, major management policy decisions, and overall direction of the Project. Dr. Franczak and Ms. Dye have extensive experience in managing services for the target population. In addition, they have both served as primary investigators on previous SAMHSA grants.

Vicki Staples and Betsy Byler will serve as the key ADHS/BPSMI staff for facilitating the day to day operations of the project. Both have received special training on integrated mental health and substance abuse treatment and will coordinate technical assistance as well as provide direct information and training to consumers and family members. Ms. Staples and Byler have served as case management supervisors for individuals who are members of the population which will receive the benefit of the grant activities.

Ms. Sheila Lopez will facilitate and coordinate consumer and family participation. Ms. Lopez served as Program Director of Survivors United for eight years and has served on the Arizona State Hospital Human Rights Committee.

Mr. Raymond Thomas will assist in recruiting a culturally competent and diverse work group. Mr. Thomas has been involved in the ADHS/B.S. Cultural Competency efforts since their inception.

Michael Shafer, Ph.D. from the University of Arizona, Division of Community Rehabilitation will perform the evaluation.

Lee Sechrest, Ph.D. from the University of Arizona. Department of Psychology will serve as the statistical consultant. Drs. Shafer and Sechrest have served as evaluators on a number of SAMHSA grants.

Consultant services have been solicited from states and agencies that have established integrated mental health and substance abuse treatment and from experts recommended to the Arizona Department of Health Services. Consultants have been selected based on their specific knowledge and experience with establishing Integrated Mental Health and Substance Abuse Treatment.

Joel Dvoskin, Ph.D. serves as a adjunct faculty member at the University of Arizona and is a national

expert on mental health systems, forensic psychology and the treatment for dually diagnosed offenders. Dr. Dvoskin will assist the work group in the process of identifying barriers, developing strategies to overcome them and developing the implementation plan.

Kenneth Minkoff, M.D. is a national expert with extensive experience in the development of "best practice" models for individuals with dual diagnoses. Dr. Minkoff will provide training to the work group and assist them in establishing the "best practice" model. Dr. Minkoff will also assist the work group in developing strategies to overcome barriers and methods to deal with the unique situations that may be present in Arizona.

Robert Drake, M.D. is also a national expert in dual diagnosis "best practice". He will also work with the work group in developing the integrated treatment model and assist in overcoming obstacles.

ADHS/DBHS has successfully applied for and managed grant awards for programs for persons with serious mental illnesses. ADHS has managed community support, substance abuse treatment, jail diversion, state indicators and housing grants.

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ATTACHMENT II

Cooperative Agreement for State Treatment Outcomes and Performance Pilot Studies Enhancement

ARIZONA TOPPS II

GFA # TI-98-005
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

Submitted By

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PROGRAM NARRATIVE

A. Project Background and Goals

1. Performance Measurement and Research Overview: Arizona

States engaged in health care reform must increasingly address client improvement in an environment of cost containment in order to justify resources devoted to drug and alcohol treatment. A constellation of factors have led Arizona to more aggressively collect, promote and utilize data addressing statewide need and resource for substance abuse treatment, including issues of client outcome in treatment. Among the most significant developments were system wide refinements in the capability of Arizona's MIS systems to capture measures of program performance, as well as the development of tools, such as the Arizona Level of Functioning Assessment (ALFA), to allow for comparisons in patient functioning over time.

For very similar reasons, the Center for Substance Abuse Treatment released an RFP for Treatment Outcome Performance and Pilot Studies in 1996. The project allowed Arizona and other TOPPS I states to develop and collect a body of rigorously-developed data demonstrating the efficacy of substance abuse treatment based on studies conducted on Arizona client populations.

Arizona has also pursued a variety of research projects to provide data on the extent of need and demand for treatment services within the state. These include:

A. Arizona Substance Abuse Needs Assessment Study (AzNAS)
Largest study of substance abuse prevalence ever conducted in Arizona. Recently funded for a second 3 years.

- AzNAS I: Scope out the size of the problem: How many people in Arizona need substance abuse treatment and where do they live? What are the barriers to seeking treatment? Sample of 10,000.

- AzNAS II: Gaps Analysis: Is the current substance abuse treatment system sufficient to meet the needs of Arizonans who need services? Who pays for the care: Medicaid & IHS studies; sample of 2,700? What types of treatment/levels of care are needed (ASAM)? What types of programs are available (MCO/Provider Profiles)?

B. Methadone Treatment Quality Assurance System (MTQAS)
Seven state demonstration project to establish outcome indicators for methadone treatment and measure client progress over time. Includes suicidal behavior, use of hospital ERs, use of detox, and employment status. Sample includes all clients in 15 Arizona programs, both private and publicly

supported

C. Treatment Outcome Prospective Pilot Study (TOPPS I)

First prospective cohort study of substance abuse treatment clients in Arizona. Uses the ALFA scale to measure functional status at intake and client improvement at discharge and at 6 and 9 months post-discharge. Sample of 1,200. Will provide unprecedented information on the effectiveness of treatment in a managed care treatment delivery system.

Information drawn from the AzNAS and the TOPPS I projects, in particular, offer rich sources of data for developing measures of system performance and treatment outcome. For example, a penetration rate for each MCO catchment area can be derived from AzNAS data through the ratio of # of individuals treated/# in the community who need/want treatment.

Secondly, a major focus of Arizona's efforts currently is the development and application of performance indicator data from various sources to inform policy making, improve the quality of patient care, and guide purchasing/contracting decisions for substance abuse treatment. While data from TOPPS I can be used to establish baseline expectations for client outcomes, TOPPS II provides the opportunity to "norm" both outcome (individual) and performance (systemic) indicators over time and benchmark against other states' experiences.

2. Literature Review: Performance and Outcome Measures for Systems Monitoring

State of the Art

Pressed by legislative demands for increased accountability and the need to more closely manage the delivery of mental health care, a variety of initiatives to measure the performance and justify the investment of tax dollars have been underway in the past few years. Most efforts to define and develop indicators for substance abuse and other mental health services appear to agree on the broad categories from which measures should be derived. For example, the Joint Commission on Accreditation of Healthcare Organizations cites two major arenas for focus: Performance Measures and Outcome Measures.[1] Performance measures include a broad array of clinical and system standards such as efficacy (will care produce the desired outcome?), appropriateness, effectiveness (is care provided at the best time?), continuity and efficiency (are outcomes in line with investments?). Proposed areas for Outcome measures focused on changes in status (health, mental health, social functioning), patient satisfaction with services, and changes in knowledge or behavior that impact future health status.

While general agreement appears to exist on the need to measure both performance and outcome, consensus on the exact measures that best capture and articulate these domains has not been forthcoming. In the recently-released 1997 Five State Feasibility Assessment Project, the Center for Mental Health Services defined a set of indicators addressing outcomes and quality of care for

adults with serious mental illness. In Perrin and Koshel,[2] the National Research Council's Panel on Performance Measures and Data for Public Health Performance Partnership Grants (PPG's) proposed a series of substance abuse measures. Categories in the NRC report were similar to those proposed by JACHCO and included both measures of expected outcome, such as health status, social functioning, and at-risk status, as well as system performance, such as access to care, capacity and quality processes. However, the standards against which the indicators were measured demonstrated closer ties to expected public health outcomes, such as those contained in Healthy People 2000, than to standards for monitoring the progress and process of clinical care.

Finally, in collaboration with the CSAT, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) convened a special data panel in the fall 1997 to address the issue of merging process and outcome measures from the National Research Council and other sources. NASADAD's indicator list, upon which the TOPPS II proposal is based, outlines a series of potential measures addressing the areas of Treatment Effectiveness, System Efficiency, and System Structure.

Overall, the NASADAD measure represent a mix of data collected at the level of individuals (self-report and clinical) and various state-level data systems, including AOD data systems (structure) and interface with other state data systems (cost-offsets). Strengths of the list include its solid focus on verifiable data, primarily through state MIS systems. Weakeness include a lack of attention to attributes of the recovery process which, while incremental, are significant predictors of long-term outcome, as well as reliance on completion rates as the primary measure of treatment retention. In Arizona's managed care environment, patients are managed across multiple levels of care, including involvement in post-discharge community recovery support groups and structured relapse prevention groups. In contrast, "completion rate" suggests an arbitray program design (30 day residential, for example), rather than services based on individual need.

Data Sources and Their Limitations

In addition to lack of national consensus around selection of the most appropriate measures are problems inherent in the reliance on public systems data. Data available for measurement are necessarily limited; most fall into two basic categories: *Sentinel Events*, are events or occurrences, usually undesirable and infrequent, that trigger a need for further review. Major examples include suicide, no-shows and patients discharged against staff advice. *Aggregate Data Indicators*, are measures which quantify a process or outcome. These include rate-based indicators (proportion or ratio) and values that fall on a continuous scale.

Regardless of the type of indicator, data sources and the quality of data are problematic. The NCR Panel listed several data sources that can support PPG measures. The Centers for Disease Control, for example, supports the National Notifiable Diseases Surveillance System (NNDSS), which monitors on a weekly basis the occurrence of a set of diseases important to public health. Two other surveys that generate state-level estimates are the National Immunization Survey and the

BRFSS. CSAT-funded projects, including TOPPS I, the Methadone Treatment Quality Assurance System, and the State Demand and Needs Assessment Program are valuable sources of data specific to individual states that allows for some comparisons on a regional or national basis.

While these data sources are strengthened by rigorous attention to technical detail in data collection as well as comprehensive quality assurance processes, data available through state AOD agency and other state-level systems is often more problematic. Methodological and conceptual issues to consider in data collection for MIS performance systems include:

(1) Are quality assurance processes in place to continuously improve data reliability?
(2) Are key concepts operationalized in a consistent fashion across the state (e.g. intake, discharge, treatment completion)?
(3) What is the data submission lag time?
(4) Are providers "incented" to mislabel data?
(5) Do cause-effect relationships between treatment processes and patient outcomes exist?

A final consideration lies in the meaningfulness of the measures, once collected and translated into rates. What, in fact, should be expected as the outcome? Are the observed rates normative and, if so, are those norms what should be? How can providers and MCOs be incented so that measures improve over time?

The Arizona TOPPS II project proposes to address data limitation issues in a variety of ways, including development of a "gold standard" for ascertaining whether measures observed in MIS data meet or exceed our expectations for system performance and patient outcome.

Measurement Issues Related to Gender and Culturally Competent Services

A recent spate of articles on gender and culturally competent services were reviewed to ensure that Arizona TOPPS II is adequately sensitive to the differing needs, expectations, and outcomes observed among different populations. In Annis, Sklar, and Moser (1997), for example, gender in relation to relapse crisis situations, coping, and outcome was recently studied among treated alcoholics.[3] In this study, relapse crisis situations resulting in successful coping (i.e., abstinence) and unsuccessful coping (i.e.,relapse) were examined in 90 male and 35 female alcoholic clients over the first 12 weeks following treatment discharge. More similarities than differences were observed between the genders in the relapse crisis situations encountered, the number and type of coping strategies used, and the drinking outcome results. A similar proportion of males and females successfully abstained in the first 12 weeks posttreatment; a combination of cognitive and behavioral coping was most frequently used by both genders, and negative emotional states constituted the most commonly reported relapse crisis situation. Survival of a relapse crisis was strongly associated with the number of coping strategies used by both men and women. There was a nonsignificant trend for females to relapse more frequently in negative affect situations (i.e., negative emotions, conflict with others) and males in the presence of other drinkers.

Copeland (1997)[4] studied the qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours. The author found that even though alcohol and drug abuse and dependence are common disorders in our society, the vast majority of those who recover do so without formal treatment. Although this phenomenon appears to be more common among women than men there has been no gender-sensitive research. This qualitative study explored the barriers to formal treatment seeking among women who self-managed change in their alcohol and other drug dependence. The principal barriers identified included social stigma and labeling, lack of awareness of the range of treatment options, concerns about childcare, the perceived economic and time costs of residential treatment, concerns about the confrontational models used by some treatment services, and stereotypical views of clients of treatment services. The author recommended improving outreach activities, the use of nonconfrontational therapeutic style, understanding and agreeing upon outcome goals, and evaluation of treatment costs.

In Aktan (1998)[5], the evolution of a substance abuse prevention program with inner city African-American families was analyzed. The author found that substance abuse prevention programs successfully implemented and shown to be effective through rigorous evaluation must be able to respond to participant needs and changing environments in order to sustain themselves. The author emphasizes the need to respond to participant needs and changing environments to enhance sustainability and calls for flexible evaluation components to accommodate the dynamic nature of substance abuse prevention programs.

Plange (1998)[6] analyzed the social and behavioral issues related to drinking patterns. The focus was on patterns of drinking and their outcome, with special emphasis on the patterns of alcohol use affecting mood and behavior that lead to multiple health and societal consequences. Examples of social drinking patterns in Truk, Fiji, and Iceland illustrate culturally acceptable but inappropriate patterns of drinking and their outcomes. Excessive drinking has a negative outcome for individuals and for society, and a regulated, moderate, and responsible pattern of drinking has a positive outcome on health and well-being.

In Zane, et. al (1998)[7], the authors analyzed dosage-related changes in a culturally-responsive prevention program for Asian American youth. The study identified aspects of the intervention that were related to outcome changes in order to better understand what accounts for the culturally responsive nature of this program. CTT participants were more knowledgeable about drugs and about the negative influences of drugs after completing the program during the school year. Also, there was a significant increase in school competence, but no significant change in their perception of family relations. CTT evinced much less effect on youth and family participants when the program was conducted in the summer in that nopre-post outcome changes were found for the summer-based intervention. The investigators discuss the ways in which the dosage differences between the school and summer programs may have contributed to the observed differences in outcomes.

None of these recent articles have analyzed cultural issues in relation to American Indians

or Hispanic populations, two of the populations targeted in Arizona TOPPS II.

3. Purpose of the Application

The purpose of this application is to participate in a nationwide project among selected states to define common indicators of performance and patient outcome for substance abuse treatment services. Participation in the national Steering Committee offers the unique opportunity to benchmark specific measures against other states' experiences in order to determine if normative indicator data is what should be expected. Arizona TOPPS II is composed of four components that allow for validation of data collected from self-report and establish measures for trending system performance.

Arizona TOPPS II Goals and Objectives

(1) To develop and refine a set of agreed-upon measures of system performance and patient outcome utilizing a facilitated, consensus panel process.
   a) Develop numerators/denominators that can be "normed" in BHS data system.
   b) Propose modifications to TOPPS I survey instrument based on suggested measures
   c) Develop measures relevant to unique models of care, particularly detoxification services versus structured treatment.

(2) To modify the TOPPS I patient outcome instrument, based on measures derived from the consensus panel, and conduct a two-year post-treatment outcome follow-up of the 1,200 patients in the original TOPPS I study.

(3) To conduct an internal MIS study of existing data available for performance measurement, with a particular focus on monitoring indicators relevant to SAPT Block Grant requirements, including services to pregnant/parenting women and injection drug users.
   a) Develop measures relevant to modalites excluded in the TOPPS I study (e.g. methadone maintenance, crisis services, detoxification)
   b) Provide numerators and denominators for consensus panel review and feedback.
   c) "Norm" indicators over time to identify trends and provide opportunies to benchmark against other states.

(4) To design and conduct and integrated MIS study matching public system patients to other state-level databases in the areas of hospital admissions, emergency room utilization, relapse, criminal involvement, public assistance utilization and access to care for pregnant women in Medicaid health plans.
   a) Verify self-reported data from the TOPPS I patient sample by obtaining pre/post measures for "episodes" in other state data systems.
   b) Derive cost-offset and utilization data for all treatment clients in other tax-supported service systems, including criminal justice, welfare, and primary care.

(5) To integrate outcome and performance measures data derived from TOPPS I and II into system improvement initiatives, including performance benchmarks for subcontracting and MIS modifications that allow effective monitoring of SAPT Block Grant requirements.

a) Develop fields for monitoring involvement in other state agency systems, including criminal justice, welfare and primary health care.

b) Develop fields and algorithms for routine reporting of Block Grant population requirements and patient outcomes.

(6) To participate, with other TOPPS II states, in a cooperative Steering Committee to determine an appropriate set of measures for treatment outcome and performance at the national level.

a) Develop consensus measures for national reporting

b) Benchmark field and MIS data against other states

B. Project Approach/Plans

1. State of the Art in Performance Measurement in Arizona

Arizona health care system reform in the early nineties mandated integration of behavioral health services and capitation in lieu of grant funding. The state legislature, Medicaid Agency, and BHS/ADHS took steps to achieve these objectives, and Arizona has emerged as a leader in the public managed behavioral health industry. Currently, Arizona uses a small set of indicators to monitor its regional MCOs. These include:

(1) Active to Open Client Ratio (Standard = $\geq$ 90%)
This ratio provides a comparison of active substance abuse/general mental health clients (those who have received at least one service in the past 120 days) to all substance abuse/general mental health clients enrolled in the system. It provides useful information to BHS/ADHS regarding time lags in provider billing, intake and discharge processes which, in turn, reflects RBHA emphasis on managing client rosters. As such, it is largely a *system process*, rather than an *outcome*, measure.

(2) Ethnic Representation (Standard = $\geq$ 100%)
This ratio provides information on the proportion of service dollars (expenditures) by ethnic group versus the proportion of ethnic groups in the population (Census data).

(3) Referral to Intake Within 7 Days (Standard = $\geq$ 90%)
This ratio provides information on access and rapidity of care.

(4) Defensive Interval (Standard = >30 days)
Measures an MCO's/provider's ability to sustain operations should all incoming funds cease.

(5) Financial Viability Ratio (Standard = 1.0)
Measures current assets against current liabilities

Arizona TOPPS I was the first state initiative to develop baselines for patient outcomes. Entering the field data collection phase in July 1998 through July 1999, TOPPS I will provide unprecedented baselines on the long-term outcomes of care in various modalities.

2. Standardized Assessment Instrument/Clinical MIS Features

Measurement of patient outcome implies the need for a standardized assessment tool. Since 1992, a consistent focus of the BHS Medical Director's Office has been the design and validation of the Arizona Level of Functioning Assessment (ALFA). The ALFA was developed as a clinical risk management tool for Arizona's managed care treatment delivery system. The ALFA utilizes both DSM diagnosis and an assessment of patient functional level to predict the intensity and/or type of support services clients require. For example, patients with a combination of diagnosis and functional level indicating intensive service needs are generally unable to access services themselves and frequently require both case management and a more supportive treatment environment (e.g. residential or in-home setting, rather than outpatient or clinic).

Six functional domains are currently measured in the ALFA: (1) Family/Living Situation; (2) Interpersonal Relations; (3) Self Care/Basic Needs; (4) Substance Use; (5) Medical/Physical; and (6)
Role Performance. Completion of the ALFA on all adults and children in the Arizona behavioral health system at intake, every six months and at discharge has been a BHS/ADHS requirement since January 1997. ALFA outcomes are currently maintained by the BHS Medical Director's Office, with analyses performed by the BHS Bureau of Quality Assurance and Managed Care.

As operationalized in the TOPPS I, the ALFA Substance Abuse Outcome Version allows for prospective assessment of client outcomes at three points in time post-discharge using simple measurements of patient progress in each functional domain. These measures will be compared to initial severity at intake to determine which type of clients perform better in which treatment settings as well as issues surrounding offsets in health care, criminal justice and other arenas relating to substance abuse treatment. All data in TOPPS I are self-report.

3. MIS System Capabilities

Over the past four years, BHS has made great progress in developing the system capacities needed to support statistical activities. As an outgrowth of these efforts, the current system permits collection, analysis, and reporting of data which are used for systems management, policy decisions, evaluation, performance assessment, and research in the State. The information system requirements of BHS and its regional MCOs are quite advanced due to the combination of Title XIX claims

requirements, a capitated reimburse structure, the need for integration across five difference regional MCOs and the need for an interface between multiple database. The following databases comprise the BHS MIS system:

(1) Electronic Claims Processing
Cliams processing and service authorization support, including intake information on treatment patients.

(2) Client Information System
Mainted by BHS to monitor services delivered to patients. CIS is a decision support system containing data extracted from the claims system, including assessment, intake, service autorization and claims details. Specific fields include: dates of intake, dates of service, provider site, discharge date, demographic information (residence, income, family size, special population including pregnant women and injection drug users, dual diagnosis, etc.), services authorized (type, units).

(3) MCO Information Systems
Maintained by MCOs to facilitiate management and utilization review functions, including contract management, provider network and third party collection activities.

(4) BHS Information Systems
Internal databases that track consumer satisfaction from the annual consumer survey, quality management data from the community audit protocol and quality management data from the case file review audit. Currently, the ALFA is maintained as an internal database.

The primary point of contact for patients entering the system is the Claims Processing Database. In this system, providers enter intake and eligibility information in order to receive a service authorization and receive renumeration for services. Intakes must be entered within seven days of first service. Each client intake record, which serves as the link between all BHS data systems, contains a unique patient-identifying ID.

4. Arizona TOPPS II State/Inter-State Approach

Arizona TOPPS II proposes a set of three performance and outcome studies coordinated through an umbrella consensus panel. Each study is designed to support the development and refinement of performance and outcome measures to be incorporated into the state MIS, using a mixture of both integrated data systems and field study samples. These studies are designed to meet CSAT's goals and objectives for TOPPS II: to support inter-State consensus based decision making regarding the development of standardized AOD treatment performance and outcome measures. Arizona's research interest is shaped by the following project questions:

State Approach

(1) How can management information systems or performance and outcome monitoring systems be developed to address treatment outcomes and peformance issues?
Arizona proposes to develop a set of agreed-upon indicators for measuring treatment performance (both systemic and outcome) through a consensus panel process involving representatives of BHS, regional MCOs and substance abuse providers. In addition to developing parameters and specific measures (numerators and denominators), the panel will separately consider the choice of indicators relevant to varied models of care, particularly detoxification services versus structured treatment, as well as the differeing needs of culturally diverse populations. Measures developed by the panel will be used to modify the TOPPS I patient outcome survey for a two-year follow-up interview of the long-term effects of treatment.

(2) What are the outcomes of different treatment modalities on the substance abuse client population to be measured?
The Arizona TOPPS I project is a prospective study of 1,200 treatment clients interviewed at three points in time post-treatment discharge. Analyses were specifically designed to address level and intensity of care across four areas: outpatient, intensive outpatient, short-term residential, long-term residential. In TOPPS II, Arizona proposes a two-year follow-up interview with the same patient sample to ascertain the long-term effects of structured treatment and matching data back to the level of care of the TOPPS I study. Validation of self-reported data will be conducted through review of the BHS MIS (relapse) and an Integrative Study of other state data systems (criminal justice, emergency room, hospital admissions, TANF, pregnant women in Medicaid health plans).

(3) What special procedures are necessary to evaluate vulnerable populations as they proceed from intake to follow-up?
Decision support for the consensus panel process includes a special study of the BHS MIS system. Of particular interest will be measures capable of addressing SAPT Block Grant and quality of care standards for pregnant women, women with children and injection drug users. Once an indicator is selected, data for numerators and denominators will be culled on a quarterly basis and "normed" over the course of the three-year TOPPS II project. Comparisons of Arizona data against data from other TOPPS II states will provide an invaluable opportunity to benchmark and consider issues of expectations for the outcomes of care.

Inter-State Approach

(1) Can similar outcome measures be used regardless of the mechanism by which State fund substance abuse services?
As a participant in the national Steering Committee, Arizona hopes to benchmark its data

against the experiences of other states. Questions which naturally fallout of such an initiative include those surrounding differences that may result from funding and entitlement status, public, legislative and state AOD agency expectations around how much progress should be reflected in an indicator, as well as issues surrounding regional variations. Arizona intends to participate as a full member of the committee, including coordination of the inter-state design features with those proposed for state-level implementation in TOPPS II.

5. Participatory Process

The TOPPS II consensus panel builds off activities initiated under TOPPS I to provide input into data analysis and study design from representatives of the regional MCOs and treatment providers. In TOPPS I, a special advisory group was convened through the Quality of Care Committee of the Arizona Association of Behavioral Health Providers. Membership was expanded to include a selection of substance abuse treatment facilities not currently members of the Association. TOPPS I staff meet quarterly with the advisory group to provide updates and examine data collection issues.

For TOPPS II, Arizona proposes to use the same advisory group as a core team for the consens panel. Membership on the consensus panel will be further expanded to include a variety of providers of substance abuse treatment services. Consideration will be given to involvement of representatives of other public systems impacted by substance abuse to identify measures appropriate to their expected outcomes. For example, a representative of the child welfare system may be invited to discuss potential indicators for measurement of family reunification as a treatment outcome.

Internal coordination on issues of quality of care, ALFA outcomes and MIS modifications will occur through inclusion of appropriate staff on the consensus panel. As detailed in the Management Plan, the BHS Medical Director's Office, BHS Bureau of Managed Care and Quality Assurance and the MIS Liaison will be standing members of the consensus panel.

Letters of coordination/support from the regional MCOs and substance abuse treatment providers are included as Appendix 4.

6. Target Population/Target Services

The target population for the Arizona TOPPS II project are adults receiving drug and alcohol abuse treatment services as of August 1, 1998 (e.g. field launch date for the TOPPS I sample). No exclusionary criteria have been established for the project, although certain studies (MIS Study and Integrative Data System Study) will explore the full continuum of care in a more comprehensive fashion. Primarily, TOPPS I focused on outcomes following a structured course of care and, therefore, did not include crisis services, methadone maintenace or detoxification. These levels will also not be included in the TOPPS II Two-Year Follow-Up Study. However, special indicators will be discussed in the consensus process and refined through both the MIS and Integrative Studies to

address all modalities provided in Arizona. A special feature of interest is the provision of Traditional Healer services to members of the 21 recognized Native American tribes within Arizona.

Case-mix adjustments will be applied in all data analysis in order to compare differing outcomes among different populations. The following adjustments will be conducted:

(1) *Patient characteristics*, including age, gender, entitlement status/Title XIX, race/ethnicity
(2) *Level of Care and Treatment Modality*, including methadone, detoxification, outpatient, intensive outpatient, residential
(3) *Region*
(4) *Special Population Status*, including individuals with co-occurring disorders, pregnant women, women with children and injection drug users. (CIS intake).
(5) *ALFA Severity at Intake*, including clinicians' scores for the six ALFA functional domains

The following table details the characteristics of substance abuse patients who received primary treatment and detoxification services (e.g. non-crisis) during 1996-97.

Substance Abuse Patient Characteristics: FY 1997				
	Male	Female		
18-24	2,662	1,225		
25-44	11,465	5,595		
45-64	2,386	761		
65+	200	69		
Age/Gender Totals	16,713	7,650		
Race/Ethnicity				
White	Hispanic	Nat. Am.	Asian	Black
14,837	5,683	1,707	112	1,803
Special Characteristics				
Medicaid	11%	Pregnant	1.5%	
Private Insurance	3%	Dependent Child	13%	

Uninsured	86%	IDU	19%

C. Project Design and Analysis Plan

1. Project Design

Arizona TOPPS II proposes a set of three interrelated studies capable of producing indicators and both normative and baseline data for substance abuse treatment services. Indicators developed in the course of the project include both system performance measures and patient outcome measures with differing processes for ensuring the quality and validity of the data. The studies will be refined and continously monitored through an in-state consensus panel process, as well as participation in the inter-state steering committee established through the TOPPS II Cooperative Agreement. Individual study approaches are as follows:

2. Consensus Panel Process

BHS will convene a panel of staff and representatives of the five regional MCOs, as well as treatment providers representing the mix of modalities available in Arizona (outpatient, intensive outpatient, residential, detoxification and methadone). The panel will be chaired by the TOPPS II Project Director and include other members of the TOPPS II research team. A facilitator will lead all discussions and assist in achieving group consensus. Meeting management, ongoing literature review and coordination of monthly communications to the panel (minutes of past meetings, abstracts on relevant literature, data mining and trending reports) will be managed by Hi-Tech Inc. The panel will meet monthly in Year 1 and quarterly thereafter for facilitated discussions surrounding the appropriateness and utility of various measures of system performance and treatment outcome. Normative data (numerators/denominators) drawn from the BHS MIS system will be provided for discussion and trend analysis by the Rural Health Office. Trending will continue for the duration of the TOPPS II project, allowing for comparisons to literature and benchmarking with other states, as well as detection of regional differences in performance and treatment outcome.

As a member of NASADAD, Arizona is a participant in the national review of suggested performance measures developed by the NASADAD data group and proposed for inclusion in TOPPS II. Capability to measure the NASADAD set as well as many of the Arizona recomended indicators currently exists in the BHS MIS system or were developed for field application in the TOPPS I prospective study and related research initiatives, such as the CSAT Needs Assessment. Numerators/denominators for other indicators will be addressed in the three TOPPS II studies. These measures will form the basis for discussion in the consensus panel.

3. MIS Study

The TOPPS II research team will conduct data mining activities of existing BHS information systems to provide decision support data for the consensus panel process. This study will focus on system performance measures and "norming" data over time, and includes a special focus on measurements sensitive to the requirements of the SAPT Block Grant for pregnant/parenting women and injection drug users. As requirements of the Block Grant are defined in federal statutue, the consensus panel will specifically consider the following indicators, in addition to others they select:

- *System Performance*: How quickly do patients/clients access the system?
  What is the retention rate (LOS)?
- *SAPT Block Grant:* Pregnant/parenting women, IDU's access/interim treatment
- *ALFA Functional Change*: Arizona's intake assessment instrument
- *Average cost by modality:* Service value by level of care
- *Quality*: Richness of array (Number and types of services delivered)
- *Penetration rate*: Number of persons treated (BHS MIS)
  # who need and want treatment (CSAT Needs Assessment)

Case-mix adjustments, as described in section B, will be applied to all MIS data.

Planning and Development Phase

DuringYear 1, MIS tapes will be obtained and preliminary baseline data culled for panel review on a monthly basis. The outcome will be recommendations and/or other issues that will be further elaborated upon in steering committees, as desired by the consensus panel.

Implementation Phase

During Year 2, the normative data will be trended quarterly and modifications to the selected indicators by consensus of the national steering committee and the consensus panel. Based on these outcomes, modifications to the TOPPS I instrument that address system performance and new client outcome baseline will be developed.

Analysis and Dissemination Phase

Following review of Year 2 MIS data, a report will be prepared for the consensus panel, including recommendations for MIS system/field modifications.

4. Integrated MIS/Survey Verification Study

The importance of validating client self-report with objective measures is obvious. A good evaluation plan of treatment outcomes necessitates the use of independent measures that can

validate subject self-report. Such independent measures can be obtained through state agencies which collect information on the population that BHS serves.

The Integrated MIS Study serves two purposes in the TOPPS II design. First, it acts as a verification method for patients included in the TOPPS I survey and targeted for the two-year TOPPS II follow-up. The study is aimed at determining the level of under-reporting of sentinel events, including criminal involvement, relapse, and emergency room utilization, and identifies the ALFA domains within which events seriously jeopardize treatment success. Second, the study allows for an improved understanding of potential cost-offsets in criminal justice, health care and other social services through the provision of substance abuse treatment services.

To validate client self-report, the major guiding factor in selecting objective measures is the availability of such measures within the state system. In addition, these measures also need to be pertinent to the treatment outcomes to be assessed. The TOPPS I instrument assesses outcome in six domains, based on the ALFA. Several sources of data will be targeted for developing an integrated database needed to accomplish this task. Arizona proposes to utilize the following domains for self-report validation: criminal, BHS utilization, hospital and emergency room medical care. Depending upon resources and time required to complete these datasets, use of public assistance (TANF) and Medicaid services (AHCCCS) may also be added to the study.

Data Type	Data Source	Outcome/Cost-Offset Indicators
Hospital discharge data	Arizona Department of Health Services	1. Presenting problems 2. Length of stay (days) 3. Number of admissions
Emergency room data	Arizona Department of Health Services	1. Number of medical episodes 2. Number of substance abuse-related crisis episodes
Treatment utilization data	Behavioral Health Services (CIS/EDS)	1. Length of stay (days) 2. Type of services/Level of care 3. Patient characteristics
Crime data	Selected Sheriff's departments	1. Number of days incarcerated 2. Number of arrests 3. Types of crimes
TANF	Department of Economic Security	1. Participation rate

Medicaid utilization	AHCCCS health plan database	1. Number of pregnant women screened 2. Number of pregnant women referred for treatment & received it

Planning and Implementation Phase

During Year 1, appropriate agency contacts will be conducted to obtain hospital discharge, emergency room and criminal justice data. Cleaning and review of BHS treatment utilization data will proceed for the MIS study. In order to provide a pre/post treatment outcome survey verification function, databases must be secured for two points in time: ***Baseline Year:*** 1997-1998, the year prior to the field launch of the TOPPS 1 survey (July 1998); and ***Comparison Year:*** 1998-1999, the year during which the TOPPS I survey is in the field.

In order to develop the integrated database, an algorithm will be developed to accurately match client identifiers. Although client names may be available in most of the databases, other characteristics will have to be matched to minimize false positives. This could include county information, portions of social security numbers, date of birth, ethnicity, and gender. The most complete set of client characteristics will be available through the BHS data system and, for the subset of patients whose data will be verified, the demographic information collected in the TOPPS I survey. Depending on the dataset, the degree of concurrence will be determined as the decision criteria for accepting a match. A further facilitating factor is the fact that BHS data has information regarding the client's participation with other agencies, including DES and Corrections.

The following shows the types of information that can be used for matching across databases.

Database	Matching information
Hospital and Emergency room databases	Social security number or Insurance certificate number Gender Date of Birth Residence (address, zip code, county) Name
Crime database	Name Social security number Residence (address, county) Date of Birth

BHS CIS/EDS	Social security number Gender Date of Birth Residence (address, zip code, county) Name AHCCCS ID
TANF and AHCCCS	Name Social Security Number Gender Address

Potential Challenges to the Research Design

Data inaccuracy: Data obtained through the various agencies will reflect the differences in the data collection mode as well as the completeness of the information gathered. In some cases, data may be entered following a visual inspection, resulting, for instance, in ethnicity being incorrectly determined. Names may not be taken if the individuals presented with an emergency, or were unable or unwilling to furnish any information. To minimize such errors, the decision criteria to accept a match will weight some demographic characteristics more heavily than others. For example, date of birth and gender may be less subject to such errors than ethnicity.

Missing data The agency may not provide sufficient data so that a match can be made. To ensure full participation of the agencies involved, all agencies to be targeted will be asked for a commitment to facilitate the process. A certificate of confidentiality will be obtained to ensure that client confidentiality is protected. In addition, the benefits of the study will be impressed upon them (the agencies), showing the need for accurate data to determine treatment outcomes for clients who could be costly to the agencies otherwise.

Inability to establish positive outcomes unequivocally: It may be assumed that if individuals do not appear in any of the files provided by the agencies, then they did not cycle through those agencies, thus conferring "good" treatment outcomes. However, such an assumption is based on at least two other assumptions: that the clients are still residents of Arizona and did not interact with out-of-state agencies (e.g., hospitals, police departments, behavioral health agencies), and that all potential matches were accurately determined. As a checking procedure, those individuals followed up who reported having had interactions with any of the abovementioned agencies will be checked against the objective data. Absence of corroborating evidence will be further assessed to determine if this constitutes a major challenge to utilizing agency data to validate client self-report.

Analysis

A matched analysis using suitable correlations for binary outcomes will be conducted first

between self-report and indicator data for each of the domains listed earlier using dummy variables. For example, for the hospitalization variable, a mention by the client that s/he was hospitalized will be coded 1, and a match in the hospital discharge variable within the same time frame will also be coded as 1. The correlation coefficient will provide an estimate of the measure of agreement between self-report and independent data from databases. Next, to determine whether there are discernible paths that BHS clients take, the types of interactions (hospital, emergency room or criminal justice involvement) can be described using limited time sequence information. With sufficient time sequence information, the probability of various paths (e.g., cycling through emergency rooms, or criminal justice system, etc.) taken following treatment can be determined. The probability of each outcome can be estimated based on a binomial logistic regression model. The impact of covariates such as past treatment history, existence of dual diagnosis, and past psychiatric status on the predictability of particular destinations (e.g., emergency room, or jail, or more drug abuse treatment) will also be assessed. The path will provide probabilities for each stage or combination of stages.

At the conclusion of this study, an estimate of the degree of concurrence between client self-report and agency data will be produced. In addition, the various paths that clients may take following treatment will also be described, with data showing cost-offset as a consequence of treatment.

4. Two-Year TOPPS Patient Outcome Survey

This component of the study will allow us to gather outcome measures form our original TOPPS I sample at the second year post discharge. (For details on the TOPPS I research design and instrumentation, see Appendix 5: Data Collection Instruments/Interveiw Protocols)

Issues of follow-up are particularly difficult with a dynamic treatment population. Providers with particularly large homeless and transient clientele will be monitored by specially trained BRC interviewers to ensure collection of all possible follow-up and recontact information. Use of subject incentives for each data collection point will assist in subject compliance.

Planning and Development Phase

Modifications to the TOPPS I instrument will be based on consensus panel deliberations and findings from the MIS study. The sampling plan requires a follow-up for 1,200 patients originally included in the TOPPS I study and reflective of the statewide treatment census by age, gender, race/ethnicity and program size. As data collection for the TOPPS I field study winds down during early 1999, the TOPPS II team will utilize this opportunity to recontact patients to encourage their continued participation in the study and to thank them for their past involvement. Preparations for OMB Clearance will occur near the end of the year.

Implementation Phase

During Year 2, the modified survey instrument will be CATI programmed and all changes to data collection, disposition and follow-up forms completed. The field portion will begin we will

collect outcome data at the second year post discharge from our TOPPS I sample. The final data analysis plan, developed in concert with the consensus panel, will address the same major analyses detailed in the TOPPS I data analysis protocol. Self-reported outcomes will be assessed in terms of their validity through the Integrative Database Study.

The final analysis plan will include descriptive and multivariate analyses. Specific analyses include:

(a) Representativeness. The sample will be compared to client admissions data from the most recent fiscal year to ensure representativeness for the modalities under investigation.

(b) Population characteristics. General descriptive characteristics include gender, age, ethnicity, drug/alcohol use, completed/not-completed and Medicaid eligibles.

(c) Patient Outcomes. Displayed as a mean level change from intake to discharge to 6 months/9 months post-discharge for treatment completers and non-completers. Discrete variables will be assessed using percent change. Items of interest include: income and employment, education, recent arrests, continued drug use, current housing situation, length of stay in treatment, etc.).

(d) Predictors. Repeated measures analysis of variance and logistic regression will include treatment modality, length of stay, and geographic residence as categorical predictors (independent predictors). Logistic regression techniques will be used to identify, by primary client characteristics, level of care, geographic area and additional intake variables where practical, what predicts good treatment outcome for the entire treated population.

(e) Regional Differences. When possible given final sample size and margin of error, categorical predictors will be assessed using the products of modality x residence and length of stay x residence will indicate whether the relationship between program outcome and treatment modality, and length of stay differ by region.

5. Analysis and Dissemination of TOPPS II Data

Analysis plans for integration of performance and outcome measures for the three TOPPS II studies will be developed in concert with the consensus panel. Although a variety of internal reports from MIS data will be generated for consensus panel review, formal reports will occur on an annual basis and reflect CSAT reporting guidelines: 15 months, 28 months and 36 months following award. The final report will contain a list of indicators with appropriate numerators, denominators and algorithms, for integration within BHS MIS systems.

D. Management Plan, Staffing, Project Organization and Resources

1. TOPPS II: Overall Organization

The Arizona Treatment Outcomes and Performance Pilot Studies Enhancement (TOPPS II) Study is a project of the Bureau of Substance Abuse, Division of Behavioral Health Services, Arizona Department of Health Services. The ADHS is the Single State Agency Recipient of the

Substance Abuse Prevention and Treatment Block Grants. Within ADHS, the Division of Behavioral Health Services provides leadership, policy guidance and administrative functions for the publicly-funded mental health system, including drug and alcohol treatment. Within BHS, the Bureau of Substance Abuse is one of three population-specific program offices with specific expertise in drug and alcohol treatment programming. TOPPS I and II Project Director Christina Dye is a full-time employee of the BSA.

2. TOPPS II Management Structure / Project Feasibility

For TOPPS II, the Bureau of Substance Abuse proposes the same personnel and management structure which was successfully implemented during TOPPS I and is leading to the success of that project.

- **Subcontracts/Project Management.** Christina Dye, Project Director, holds direct responsibility for project oversight and all subcontracting relationships, including those internal to ADHS (personnel, budget, facilities, procurement, etc) and those external (CSAT reporting).

- **Operations Management.** Thomas Pynn, of HI-TECH International is responsible for all day-to-day operational activities, with a particular emphasis on coordinating workflow to meet protocol/CSAT timeframes and all quality assurance activities. Mr. Pynn holds primary responsibility for development of data analysis plans, as well as conduct of data analysis for the two-year patient follow-up study. Mr. Pynn is directly supervised by Ms. Dye.

- **Data Management.** Primary responsibility for all MIS data functions lies with Jenny Chong, Ph.D. of the Rural Health Office, University of Arizona. Dr. Chong reports directly to Ms. Dye. Survey data management control lies with Behavior Research Center.

- **Data Analysis/Reporting.** As in TOPPS I, data analysis and report development falls into the purview of the TOPPS II Study Team, which works collaboratively to produce the best possible data product.

- **Report Dissemination/Marketing.** In her role as TOPPS II Project Director, Ms. Dye holds primary responsibility for marketing and dissemination. In this capacity, Ms. Dye works in a support role to the Assistant Director for BHS, the BHS Management Team, and the Regional MCO Directors in developing practical products and tools for improving the service system and advocating for new resources.

3. Management Methods / Project Feasibility

The Project Director uses a variety of methods to assure adherence to the technical protocols and compliance with CSAT and ADHS objectives.

- **Personnel.** Chief among these is recruitment and retention of key project personnel by providing multiple opportunities for training, presenting and other avenues of professional growth. Publication of results is also encouraged.

- **Team Approach.** By direct involvement of project personnel in crucial decision-making for the family of studies (e.g. TOPPS II Study Team), the Project Director cultivates ownership and commitment to the technical work.

- **Performance Standards.** Subcontracts developed for the individual studies (e.g. MIS Studies, Patient Outcome Study) contain specific performance measures to ensure that final data can support accurate prevalence estimation. These include standards for contacts, refusals, completion rates and ongoing progress reporting to the Project Manager.

- **Consultants.** Consultants are used in a highly-focused fashion. Rather than issuing a subcontracting for general work, a technical statement of work is developed for each procurement work order with specific tasks and deliverables. Although this approach requires more paper, it allows consultant work to be managed carefully to stay on target, while conserving project resources.

- **Deliverables.** Payments to subcontractors and consultants are based on specified deliverables, such as the annual workplan or a technical protocol. In addition, deliverables are designed to serve as status reports or key milestone reports that can be easily rolled up into an annual report or special project report without requiring development of additional reports. This focuses work on meeting specific milestone product objectives.

3. Key Personnel

TOPPS II Study Team

The Arizona Treatment Outcomes and Performance Pilot Studies Enhancement (TOPPS II) study is pleased to propose the same basic Study Team that comprised the TOPPS I. Based on two years' experience in conducting the family of research studies in Arizona, the TOPPS II Study Team offers continued pursuit of excellence in the conduct of studies and teamwork relationships forged over the course of TOPPS I. (See Appendix 6: TOPPS II Study Team and Project Organization Charts)

The Study Team is comprised primarily of the Project Director, Project Manager, and RHO MIS Study Director. Given the elevated degree of statistical modeling to be applied in TOPPS II, a biostatistician will serve as technical consultant to the Team. As needed, other research staff and consultants are tapped through project-specific subcontracts and work orders to provide necessary expertise. Under the guidance and direction of the TOPPS II Project Director, the Team is responsible for the uniformity, consistency and technical excellence of all studies, with a strong focus on integration of disparate data and applications in planning, policy formulation and resource allocations. Specific areas for team focus include: development of *standardized* operational

definitions, conducting interpretative analysis of each study findings and, in particular, how studies and findings are integrated and interwoven to provide whole population descriptions and models for substance abuse treatment outcomes performance measures in Arizona. In addition, the Team addresses selection of statistical methods for data analysis, establishing statistical standards for data collection and integrity of the data, and providing oversight for the overall coordination of all members of the TOPPS II "family."

TOPPS II Project Director: Christina Dye (.30FTE)

Primary responsibility for the overall direction and coordination of lies with Christina Dye, Director of the Bureau of Substance Abuse, BHS/ADHS. Ms. Dye was a senior technical proposal author for TOPPS I and has continued her role in preparing this proposal. For her work in the recent Arizona Needs Assessment project (AzNAS I), Ms. Dye was appointed a Visiting Scientist to Harvard University, National Technical Center for Substance Abuse Needs Assessment, in 1996. She is one of two Visiting Scientists so designated in the CSAT program's six-year history.

Ms. Dye provides project oversight to ensure that conduct of the studies meets CSAT's and ADHS' needs and objectives in terms of data applications in planning, budgeting, advocacy and resource allocations. Ms. Dye holds chief responsibility for adequate assurances and mechanisms to ensure the confidentiality of all MIS studies involving patient-identifying information, as well as field study protocols and informed consents. Ms. Dye is also responsible for all subcontracting relationships for TOPPS II, as well as reporting to CSAT. Finally, Ms. Dye brings more than 17 years experience in substance abuse publishing and health education to the task of creating policy products and TOPPS II reports that clearly articulate the dimension of substance abuse problems in our state and uses of needs assessment data in addressing those problems. Thus, in TOPPS II, Ms. Dye will continue her leadership as coordinator of the four studies of which the study is comprised, as well as expanding linkages with Tribal communities and statewide mental health advocacy groups, such as the Regional MCO directors and the Association of Behavioral Health Providers.

TOPPS II MIS Study Director: Jenny Chong, Ph.D. (.40FTE)

Dr. Chong holds primary responsibility for data management and ensuring the statistical quality and integrity of the MIS studies proposed under TOPPS II. Dr. Chong's particular focus for TOPPS II is the conduct of the Integrative MIS Studies, for which she is project P.I. In this capacity, Dr. Chong will provide population numerators and denominators for indicators, expert opinion on feasibility of data needs, assess the indicators for special populations, Ensure linkages between instrument and MIS/Integrative Databases studies, Dr. Chong is responsible for data analysis, data integration and reports to meet the needs of the TOPPS II workplan and the Project Director.

Dr. Chong is currently Research Assistant Professor, Department of Family and Community Medicine, University of Arizona. She has carried out research at the Department of Psychology and the Department of Community Medicine at the University of Arizona since 1990, including serving as Principal Investigator for the CSAT funded State Demand and Needs Assessment Program, now in its fourth year. In this capacity she holds primary responsibility for development of the AzNAS Social Indicator Database, and brings more than three years' experience in processing large state

agency databases, including criminal justice, hosptial discharge and death certificates, for associations with drug and alcohol use. She has published numerous articles on substance abuse treatment, homelessness and substance abuse, and has been involved in many studies of American Indians.

TOPPS Field Study Manger Joseph Oseroff (1.0 FTE)

Mr. Oseroff currently manages the TOPPS I field study as a full-time BHS employee. His responsibilities include coordination of all study operations, interviewer training and subject contact protocols, provider recruitment and retention and assisting Ms.Dye in marketing of TOPPS findings. Mr. Oseroff, under the guidance of Ms. Dye, is responsible for assuring all adequate subject protections and informed consent procedures for patients in the prospective field study. Mr. Oseroff's role in the proposed TOPPS II project includes operational management of the two-year prospective field study and expert input into the consensus panel and other studies.

TOPPS II EDP Liaison Nancy Majette (.15FTE)

Ms. Majette is offered as an in-kind match to the TOPPS II to provide technical oversight of the development of the MIS Studies. Ms. Majette currently serves as EDP Liaison for Behavioral Health Services. In this capacity she is pioneering state agency applications of GIS for performance monitoring of managed behavioral health care. Ms. Majette will serve as technical liaison for the TOPPS II Study Team in obtaining necessary datafiles from the Client Information System, as well as preparation of final documentation manuals surrounding indicators and their algorithms.

4. Subcontractors

HI-TECH International

HI-TECH INTERNATIONAL, INC. was founded in 1983 to provide information technology and training services to government and private industry. Initially, HI-TECH provided automated system design and software applications training for clients in fields ranging from telecommunications to biomedical research. Since then, the company has adapted its technical expertise while expanding services to meet the rapidly growing needs in the health and human services arena, including Arizona TOPPS I.

Evaluation is becoming more important for policy makers and practitioners in social services, education and training, and for professionals in virtually every institutional setting, from schools to community grass-roots organizations. The public is demanding more accountability and value for its tax dollars. HI-TECH conducts policy analyses and program evaluations for several clients, including the National Institute on Drug Abuse. Staff are versed in a large repertoire of social service research methods and techniques, both qualitative and quantitative.

TOPPS II Corporate Monitor: HI-TECH International: Simon Holliday (.40FTE)

Simon Holliday will serve as Corporate Monitor for this study, meeting monthly with the Project Director and other staff to ensure quality and provide corporate resources as needed to ensure that the project is completed on time and within budget. In this role, he holds primary responsibility

for administration of the consensus panel process, including recruitment of the facilitator. Mr. Holliday has a B.S. in Psychology from Sioux Falls College, and graduate studies in public administration at the University of Maryland and George Washington University. He served as Chief, Mental Health, Alcohol and Addiction Services for the District of Columbia from 1979-1982, and was Chief of the Office of Health Planning and Development from 1982-1991.

TOPPS II Project Manager: Thomas Pynn (.80 FTE)

As Project Manager, Mr. Pynn will develop the literature review and compile information on all projects. He will prepare panel notes and mailings, and supervise the facilitation of the consensus panel. For the MIS Study, he will review indicators and the methods used to carry out the MIS Study. For the MIS/Survey Verification Study, he will help design the matching criteria, coordinate and finalize the analysis plan, develop and coordinate the annual and final reports, and present and discuss findings with the consensus panel. Finally, for the Two Year Patient Outcome Survey, Mr Pynn is responsible for modifications to the instrument, a revised data analysis plan, the data analysis and final reports.

Mr. Pynn has carried out research in substance abuse since 1978, as Director of the National Drug and Alcoholism Treatment Utilization Survey (NDATUS) from 1979-1985. During those same years, he directed the State Alcoholism Profile Information System (SAPIS), and provided research analyst services to a study of drinking and smoking implemented by the General Electric Corporation. In 1983-1985, he implemented a series of youth surveys for the New York State Division of Alcoholism. From 1982-1986 he was Senior Scientist on the HCFA Alcoholism Services Demonstration project.

As Senior Consultant to the Department of State in 1989-1994, Mr. Pynn provided workshops and supported conferences in drug abuse prevention, treatment and public awareness programming to Argentina, Bolivia, Colombia, Chile, Ecuador, Guatemala, Jamaica, Mexico, Pakistan, Panama, Peru, and Venezuela. As Director of the Division of Applied Behavioral Sciences in 1992-1995, Mr. Pynn monitored and participated in the Technical Assistance Services to Communities project for CSAP, the Teen Drinking Prevention Program in eight cities across the USA, the 1994 Campaign against drinking and drugged driving sponsored by NHTSA and CSAP, and the Urban Youth Campaign. He has directed the HI-TECH International portion of the Arizona TOPPS study since 1997.

TOPPS II Biostatistical Consultant: Jeffrey Wilson, Ph.D. (.20FTE)

A new addition to the TOPPS II Study Team, Dr. Jeffrey Wilson is a senior biostatistician at the Arizona State University School of Health Administration and Policy and Professor of Statistics for the ASU Department of Economics. With specialized expertise in statistical modeling, sample design and sample weighting, and logistic regression, Dr. Wilson will serve as a per project consultant to the TOPPS II Team in developing models and analyses that support integration and interpretation of data developed during the study. In particular, Dr. Wilson provides authority and expertise in selection of statistical methods and controlling for the many sources of bias that emerge in modeling. In this capacity, he will assist in providing population parameters for indicators from

BHS data, develop algorithms for the MIS Study and the Integrated MIS/Survey Verification Study, provide sampling strategies for the processing of tapes, present findings to the consensus panel, assist in drafting of annual and final reports, and the development of sample design and weighting methods for the Two-Year Patient Outcome Survey.

TOPPS II Senior Analyst: HI-TECH International: Bonnie B. Wilford (.20FTE)

Bonnie B.Wilford will be a Senior Analyst on the project. She will review all products to ensure quality, including the analysis plan, training materials, and draft reports. As support to the Project Manager, Ms. Wilford will conduct and compile literature reviews and address technical and feasibility issues as required.

Ms. Wilford has an extensive and distinguished background in the alcohol and drug abuse field as a program director, educator, and policy analyst. In addition, she has more than 10 years of experience in the management of sophisticated, multiagency programs. Ms. Wilford's project management experience includes 10 years as Director of the AMA Department of Substance Abuse and a 3-year rotation as Director of the American Medical Association (AMA) Division of Clinical Science, during which she had overall administrative responsibility for planning, budgets, staffing, and performance of four operating departments. For 8 years, she also provided staff support to AMA advisory committees and the AMA Council on Scientific Affairs. In addition, she has served on numerous Federal advisory committees and study commissions.

2. Behavior Research Center

BRC served as the primary subcontractor for conducting the CSAT-funded Arizona Substance Abuse Needs Assessment Telephone Household Survey of more than 8,600 adults in Arizona. In this capacity, the agency delivered 1,000 more completed interviews than designated in its subcontract with ADHS, achieved a statewide refusal conversion rate of 15%, and completed interviews with 66% (statewide) of eligible households contacted. As primary subcontractor for the TOPPS II Study, BRC will replicate its data collection role in TOPPS I, including responsibility for recruitment, supervision and training of interviewers, respondent interviewing, respondent database management, and preliminary data cleaning and coding. Overall, BRC will responsible for ensuring a high response rate for the Two-Year Patient Outcome Survey sample.

Bruce Hernandez, Project Director (.05FTE)

Responsible for overall execution of the TOPPS II Two-Year Follow-Up Study in accordance with technical standards and procedures established in the research protocol, including internal procedures, implementation of the quality assurance/monitoring plan, site study management and preparation of survey progress reports. Mr. Hernandez will also assist in development of the interviewer training module and coordinate preparations for interviewer training, including recruitment of staff and supervision of the Field Manager.

Carol Dries, Sr. Project Manager (.10FTE)

Directly supervises and schedules operational activities of the field team (Field Director),

data coding team (Coding Supervisor) and computer team (Data Processing Manager) in executing the TOPPS II protocol per technical and timeframe specifications.

Field Director (.04 FTE)
Reports to the Project Manager; responsible for maintaining coordination and oversight and meeting study timeframes for all aspects of interviewing for telephone and face-to-face interviews. Directly supervises Assistant Field Director in scheduling and supervision of 10 interviewers.

Data Processing Manager (.03FTE)
Reports to the Project Manager. Responsible for coordination and scheduling of name/phone matches, data extracts for progress reports, as well as preliminary cleaning of final data base. Specifically responsible for maintaining the "look-up" file that matches completed interviews with non-respondents. Supervises quality of data entry staff.

Coding Supervisor (0.02FTE)
Reports to the Project Manager. Responsible for coordination and scheduling of all data entry and coding staff, as well as preliminary cleaning of final data base.

3. Rural Health Office / University of Arizona

Jenny Chong, Ph.D., MIS Study Director (.40 FTE)
Coordinates the RHO Team and support staff to ensure that RHO contract deliverables are submitted and to ensure overall accomplishment of objectives of the TOPPS II Study.

RHO Research Specialist Senior (1.5 FTE)
Designs and implements data match algorithms for the Integrative Study per the specifications of the MIS Study Director and the biostatistical consultant. This time-consuming task includes responsibility for trouble-shooting matches, assisting in the design of algorithmic logic and programming and processing of VAX data files.

3. RHO Research Coordinator (.25 FTE)
Responsible for the acquisition and preparing of pertinent data sets to be used in the MIS Studies, including cleaning, streamlining and specialized coding of large data sets.

The roles of all staff, together with estimated labor hours allocated by task are presented at the end of this document in Appendix 6.

LITERATURE CITATIONS

1.A Guide to Performance Improvement in Behavioral Health Care Organizations (Oakbrook Terrace, IL: JCAHCO, 1996).

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4. Copeland, J. Qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours . Journal of Substance Abuse Treatment, 14(2):183-190, 1997.

5. Aktan, G.B. Evolution of a substance abuse prevention program with inner city African-American families Drugs and Society, 12(1/2):39-52, 1998.

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ATTACHMENT III

Kenneth Minkoff, M.D.

Dr. Minkoff is the Director of Integrated Psychiatric and Addiction Services for Arbour Health System, Medical Director of Choate Health Management, and Medical Director of Arbour-Fuller Hospital. He is a board-certified psychiatrist with certificate of additional qualifications in Addiction Psychiatry, and is a nationally known expert on dual diagnosis and integration of mental health and substance disorder services. He has authored and edited numerous works, including "Dual Diagnosis of Serious Mental Illness and Substance Disorder", which he co-edited with Robert Drake, M.D. Dr. Minkoff is also Chair of the Center for Mental Health Services Public Managed Care Initiatives Panel on Co-occurring Psychiatric and Substance Disorders, a member of the board of the American Association of Community Psychiatrists, the Dual Diagnosis Committee of AACP, and is a past member of the APA Committee on the Chronically Mentally Ill. He is an experienced psychiatric administrator in outpatient and inpatient settings, and has developed considerable expertise in developing public and private managed care systems. With David Pollack, M.D., he is co-editor of Managed Mental Health Care in the Public Sector - A Survival Manual, published in 1997. Areas of consultation expertise include: psychiatric and addiction integration, managed care systems development, quality management, physician management, contracting and reimbursement, utilization management and levels of care assessment, hospital alternatives for mental health, and substance abuse.

PERSONAL DATA

Name:	Kenneth Minkoff
Address:	12 Jefferson Drive Acton, MA 01720
Home Telephone:	(508) 263-6895
Mailing Address:	Choate Health Systems, Inc. 23 Warren Avenue Woburn, MA 01801 (617) 933-6700 FAX: (617) 933-9119 E Mail: KMINKOV @ AOL.Com
Date of Birth:	December 26, 1948
Place of Birth:	Brooklyn, NY

EDUCATION

Sept. 1964 - June 1968	Harvard College, Cambridge, MA A.B. Magna Cum Laude- Physics- June 1968
Sept. 1968 - June 1969	Harvard University, Cambridge, MA Graduate School of Arts and Sciences Pre-Med Special Student
Sept. 1969 - Dec. 1972	University of Pennsylvania, Philadelphia, PA School of Medicine M.D. - December 1972

POSTDOCTORAL TRAINING

Jan. 1973 - June 1973	Graduate Hospital - University of Pennsylvania Philadelphia, PA Medical Internship
July 1973 - Dec. 1973	University of San Diego County San Diego, CA Psychiatric Internship
July 1973 - June 1976	University of California, San Diego Department of Psychiatry Psychiatric Residency

LICENSURE AND CERTIFICATION

1976	Massachusetts License # 39497
1996	Maine License # 014352
October 1977	Board Certified in Psychiatry American Board of Psychiatry and Neurology
July 1993	Certificate of Additional Qualifications: Addiction Psychiatry

ACADEMIC APPOINTMENTS

1976 - 1993	Clinical Instructor in Psychiatry Cambridge Hospital Department of Psychiatry Harvard Medical School
1994-Present	Clinical Assistant Professor of Psychiatry Cambridge Hospital Department of Psychiatry Harvard Medical School

HOSPITAL APPOINTMENTS

1976 -	Cambridge Hospital Courtesy Staff in Psychiatry
1978 - 1984	Central Hospital Courtesy Staff in Psychiatry
1980 - 1984	Somerville Hospital Courtesy Staff in Psychiatry
1984 - 1990	Choate-Symmes Health Services, Inc. Chief of Psychiatry
1985 - 1992	Metropolitan State Hospital Courtesy Staff in Psychiatry
1990 -	Choate Health Systems, Inc. Chief of Psychiatry (1990-1995)
1990 -	Winchester Hospital Courtesy Staff in Psychiatry
1990 -	Symmes Hospital (Medical Center at Symmes) Chief of Psychiatry (1990-1994)
1992 -	Saints Memorial Hospital Courtesy Staff in Psychiatry

HOSPITAL COMMITTEES

1984 - 1990	Choate-Symmes Medical Executive Committee
1990 -	Choate Health Systems, Inc. Credentials Committee Quality Assurance Committee Utilization Review Committee

MEMBERSHIPS AND PROFESSIONAL SOCIETIES

1978	APA AD HOC Committee on the Chronic Mental Patient
1983 -	Group for the Advancement of Psychiatry Committee on Psychiatry and The Community Committee Chairman (1986-1993)
1984 -	Massachusetts Psychiatric Society Committee of Psychiatric Unit Directors (1984-1994)
1984 -	American Psychiatric Association Committee on Chronic Mentally Ill (1989-1991; 1993-1996)
1989 -	American Association of Community Psychiatrists Board of Directors (1990-)
1989-1992	American Association of General Hospital Psychiatrists
1992 -	American Association of Psychiatrists Dual Diagnosis Committee (1993 -)
1993-1994	American Hospital Association Section for Psychiatry and Substance Abuse, Governing Council
1993 - 1997	American College of Psychiatrists
1996 -	Substance Disorder Advisory Council, National Council of Community Mental Health Centers
1996 -	Clinical Advisory Committee, Massachusetts Behavioral Health Partnership

PROFESSIONAL EXPERIENCE

July 1976 - June 1978

Title: Medical Director
Day Treatment Center
Somerville Mental Health Clinic

Description: Working with the Director of Day Center, an occupational therapist, I was responsible for administration, coordination, clinical supervision, and case management in a full-time day treatment program with forty clients and eleven staff.

June 1978 - April 1984

Title: Clinic Director
Somerville Mental Health Clinic

Description: Functioned as the Clinical and Administrative Director of a large community mental health clinic (fifty staff) serving adults and children in a working-class city. Responsible for clinical leadership, program development, budgeting, grant-writing, staff training and supervision, personnel management, program evaluation, and working with the community Board of Directors.

May 1984 - June 1990

Title: Chief of Psychiatry
Choate-Symmes Health Services, Inc.

Description: Responsible for management and coordination of psychiatric and addiction inpatient unit, emergency services, addiction day treatment, consultation and liaison, and outpatient services; as well as coordination with other private and public providers in catchment area.

June 1990 - Dec 1995

Title: Chief of Psychiatric Services
Choate Health Systems, Inc.

Description: Directing clinical services in a freestanding psychiatric hospital. Responsible for management and coordination of psychiatric and addiction inpatient unit, Respite Services, Psychiatric Day Treatment, Emergency Services, Addiction Day Treatment consultation and liaison, and outpatient services; as well as coordination with other private and public providers in catchment area.

PROFESSIONAL EXPERIENCE contd.

Jan. 1996 - Title: Medical Director
Choate Integrated Behavioral Care

Description: Company-wide Medical Director of a national public/private integrated psych and addiction managed-care oriented provider system. Responsible for overall quality enhancement, standards, clinical policies and procedures, and training; recruitment and supervision of 15-20 Medical Directors; and consultation to Regional Directors and Program Directors in over 20 inpatient and outpatient programs and/or provider networks.

MAJOR PRESENTATIONS 1988 - 1994:

Over 100 presentations on Dual Diagnosis of Mental Illness and Substance Disorder, plus various other topics including:

- "Paradoxes in Training Residents to Treat Schizophrenia"
- "Beyond Deinstitutionalization"
- "Young Adult Chronic Patients"
- "Paradoxes in Training Residents to Treat Schizophrenia"
- "A Family Affair: Training Professionals to Work with Families of People with Schizophrenia"
- "Helping Families of the Mentally Ill"

MAJOR PRESENTATIONS 1995:

January 1995	Dual Diagnosis St. Petersburg, FA
February 1995	Dual Diagnosis Community Health Living Worcester, MA
February 1995	Dual Diagnosis American Association of Community Psychiatrists Pinehurst, NC
February 1995	Dual Diagnosis Saints Memorial Hospital Lowell, MA
February 1995	Dual Diagnosis PMH/DPH Conference Andover, MA
March 1995	Public Sector Managed Care White Plains, NY
March 1995	Dual Diagnosis Champaign, IL
March 1995	Dual Diagnosis Metrowest Medical Center Natick, MA
March 1995	Dual Diagnosis Los Angeles County MH/SA Los Angeles, CA
March 1995	Dual Diagnosis North Essex Mental Health Clinic Haverhill, MA
March 1995	Dual Diagnosis Massachusetts Clubhouse Coalition Northboro, MA

April 1995	Dual Diagnosis D.M.H. Homeless Team Boston, MA
May 1995	Dual Diagnosis Medfield State Hospital Medfield, MA
May 1995	Dual Diagnosis AtlantiCare Hospital Lynn, MA
May 1995	Dual Diagnosis Addison Gilbert Hospital Gloucester, MA
May 1995	Dual Diagnosis Northeast Family Institute Vermont
May 1995	Dual Diagnosis Choate Conference Burlington, Vermont
May 1995	Dual Diagnosis A.P.A. Conference Miami, FL
June 1995	Dual Diagnosis IAPSRS Conference Boston, MA
June 1995	Dual Diagnosis DMH/DPH Conference Andover, MA
July 1995	Dual Diagnosis Cape Cod D.M.H. Hyannis, MA
August 1995	Managed Care System Consultation Des Moines, Iowa
August 1995	Dual Diagnosis Athens (Georgia) C.M.H.C.
September 1995	Dual Diagnosis Veterans National Conference San Diego, CA
September 1995	Public Sector Managed Care Vermont

October 1995	Dual Diagnosis Half-day Workshop (Chair) Institute for Psych Services Boston, Ma.
October 1995	Public Sector Managed Care Half-day Workshop (Co-chair) Institute for Psych Services Boston, MA.
October 1995	Residency Training with SPMI Institute for Psych Services Boston, MA.
October 1995	Dual Diagnosis Riverside CMH Needham, MA.
October 1995	Dual Diagnosis and Family/ Consumer/ Provider Collaboration. Vermont AMI
November 1995	Dual Diagnosis Metrowest Dual Diagnosis Task Force Marlborough, MA.
November 1995	Dual Diagnosis Park Ridge Hospital Rochester, NY
November 1995	Dual Diagnosis Tennessee Hospital Association Nashville, TN
December 1995	Dual Diagnosis Northampton VAH Northampton, MA.
December 1995	Dual Diagnosis Riverside County MH/SA Riverside, CA.

PUBLICATIONS: ORIGINAL REPORTS

1. Minkoff K., Bergman E., Beck A., and Beck R. "Hopelessness, Depression and Attempted Suicide." *American Journal of Psychiatry*, 130 (4:455), April 1973.

2. Holding T. and Minkoff K. "Parasuicide and the Menstrual Cycle." *Journal of Psychosomatic Research*, 17 (365), December 1973.

3. Morrison J. and Minkoff K. "Explosive Personality as a Sequel to the Hyperactive Child Syndrome." *Comprehensive Psychiatry*, 16 (343), 1975.

4. Goldhaber S., Conn S., and Minkoff K. "An Obsessive-Compulsive Neurotic Patient in Crisis." *Western Journal of Medicine*, 127, 120-128, 1977.

5. Stern R. and Minkoff K. "Paradoxes in Programming for Chronic Patients in a Community Clinic." *Hospital and Community Psychiatry*, 30 (9), 613-617, 1979.

6. Minkoff K. and Stern R. "Paradoxes Faced by Residents Being Treated in the Psychosocial Treatment of People with Chronic Schizophrenia." *Hospital and Community Psychiatry*, 36 (8), 859-864, 1985.

7. Minkoff K. "Resistance of Mental Health Professionals to Working with the Chronic Mentally Ill." *New Directions for Mental Health Services*, Jossey-Bass, 33, 3-20, 1987.

8. Minkoff K. "Beyond Deinstitutionalization: A New Ideology for the Post-Institutional Era." *Hospital and Community Psychiatry*, 38 (9), 945-950, 1987.

9. Trotter C., Minkoff K., Harrison K., and Hoops J. "Supported Work: An Innovative Approach to the Vocational Rehabilitation of Persons who are Psychiatrically Disabled." *Rehabilitation Psychology*, 33, 27-36, Spring 1988.

10. Minkoff K. "Development of an Integrated Model for the Treatment of Patients with Dual Diagnosis of Psychosis and Addiction." *Hospital and Community Psychiatry*, 40 (10), 1031-1036, October 1989.

11. Batten, H., Bachman S., Higgins R., Mannik N., Parham, C., and Minkoff K. "Implementation Issues in Addictions Day Treatment." *Hospital and Health Services Administration*, 34 (3), 427-439, Fall 1989.

12. Faulkner L., Cutler D., Krohn D., Factor R., Goldfinger S., Goldman C., Lamb H.R., Lefley H., Minkoff K., Schwartz S., Shore N., and Tasman A. "A Basic Residency Curriculum Concerning the Chronically Mentally Ill." *American Journal of Psychiatry*, 146 (10), 1323-1327, October 1989.

13. R. Drake, P. McLaughlin, B. Pepper, K. Minkoff. "Dual Diagnosis of Major Mental Illness and Substance Disorder: An Overview." *New Directions for Mental Health Services*, Jossey-Bass, 50, 3-13, 1991.

14. K. Minkoff. "Program Components of a Comprehensive Integrated Care System for Serious Mentally Ill Patients with Substance Disorders." *New Directions for Mental Health Services*, Jossey-Bass, 50, 13-27, 1991.

15. S. Bachman, H. Baron, K. Minkoff, R. Huggins, N. Manzik, D. Mahoney. "Predicting Success in a Community Treatment Program for Substance Abusers." *American Journal on Addictions*, 1(2), 155-167, 1992.

16. K. Minkoff. "Development of a Training Guide for Psychiatric Residents in the Psychosocial Treatment of People with Long-Term Mental Illness." *Innovations & Research*, 1 (3), 31-34, Summer 1992.

17. H.R. Lamb, S. Goldfinger, D. Greenfeld, K. Minkoff, J. Nemiah, J. Schwab, J. Talbot, A. Tasman, L. Bachrach. "Ensuring Services for Persons with Chronic Mental Illness Under National Health Care Reform." *Hospital and Community Psychiatry* 44(6), 545-546, June 1993.

18. K. Minkoff. "Intervention Strategies for People with Dual Diagnosis." *Innovations & Research*, 2 (4), 11-17, 1993.

19. K. Minkoff. "Community Mental Health in the Nineties: Public Sector Managed Care." *Community Mental Health Journal*, 30 (4), 317-321, August 1994.

20. K. Minkoff. "Models for Addiction Treatment in Psychiatric Populations." *Psychiatric Annals*, 24 (8), 412-417, August 1994.

REVIEW:

1. K. Minkoff.
"A Map of the Chronic Mental Patient" in *Task Force Report of the American Psychiatric Association Ad Hoc Committee on the Chronic Mental Patient*, Washington, DC: American Psychiatric Association, 11-37, 1978.

BOOK CHAPTERS:

1. K. Minkoff. "Treating the Dually Diagnosed in Psychiatric Settings" in N. S. Miller (ed). *Treating Coexisting Psychiatric and Addictive Disorders: A Practical Guide*, Centercity, MN: Hazelden Educational Materials, 1994.

2. K. Minkoff. "Dual Diagnosis in Seriously and Persistently Mentally Ill Individuals: An Integrated Approach" in J. Vaccaro and G. Clark (eds). *Practicing Psychiatry in the Community*, Washington, DC: American Psychiatric Press, Inc., 221-253, 1996.

3. K. Minkoff, S. Soreff. "Dual Diagnosis - Serious Mental Illness and Substance Abuse: One Person, Two Major Problems, One Approach" in S. M. Soreff (ed). *Handbook for the Treatment of the Seriously Mentally Ill*, Seattle: Hogrefe & Huber, 315-323, 1996.

4. K. Minkoff. "Integration of Addiction and Psychiatric Treatment" in N. S. Miller (ed). *The Principles and Practice of Addictions in Psychiatry*. Philadelphia. 191-199, 1996.

5. K. Minkoff. "Resistance of Mental Health Professionals to Working with People with Serious Mental Illness" in L. Spaniol, C. Gagne, and M. Koehler (eds). *Psychological and Social Aspects of Psychiatric Disability*, Boston: Center for Psychiatric Rehabilitation, 334-347, 1997.

6. K. Minkoff. "Public Sector Managed Care and Community Mental Health Ideology" in K. Minkoff and D. Pollack (eds). *Managed Mental Health Care in the Public Sector: A Survival Manual*. Amsterdam: Harwood Academic Publishers, 13-24, 1997.

7. B. McFarland, K. Minkoff. "Utilization Management, Part I" in K. Minkoff and D. Pollack (eds). *Managed Mental Health Care in the Public Sector: A Survival Manual*. Amsterdam: Harwood Academic Publishers, 151-157, 1997.

8. K. Minkoff. "Integration of Addiction and Psychiatric Services" in K. Minkoff and D. Pollack (eds). *Managed Mental Health Care in the Public Sector: A Survival Manual*. Amsterdam: Harwood Academic Publishers, 223–246, 1997.

9. A. Berger, K. Minkoff, M. Shore. "Research: System, Program, and Clinician Level Measures" in K. Minkoff and D. Pollack (eds). *Managed Mental Health Care in the Public Sector: A Survival Manual*. Amsterdam: Harwood Academic Publishers, 309–320, 1997.

10. A. Tasman, K. Minoff. "Training Issues in Public Sector Managed Mental Health Care" in K. Minkoff and D. Pollack (eds). *Managed Mental Health Care in the Public Sector: A Survival Manual*. Amsterdam: Harwood Academic Publishers, 321–330, 1997.

BOOKS:

1. Group for the Advancement of Psychiatry, Committee on Psychiatry and The Community. *A Family Affair: A Guide for Professionals Working with Families of the Chronically Mentally Ill*. GAP Report #119, NY: Brunner-Mazel, 1987.

2. K. Minkoff, R.E. Drake (eds). *Dual Diagnosis of Serious Mental Illness and Substance Disorder*. San Francisco: Jossey-Bass, 1991.

3. Group for the Advancement of Psychiatry, Committee on Psychiatry and the Community (K. Minkoff, Chairman). *A Resident's Guide to Treatment of People with Chronic Mental Illness*. GAP Report #136, Washington DC: American Psychiatric Press, 1993.

4. K. Minkoff, D. Pollack (eds). *Public Sector Managed Mental Health Care: A Survival Manual*. Amsterdam: Harwood Academic Publishers, 1997.

ıeth Minkoff, M.D.

AFFILIATIONS

kton Hospital
Centre Street
kton, MA 02402
-Present

Choate-Symmes Hospital
21 Warren Avenue
Woburn, MA 01801
1984-1990 (closed due to bankruptcy)

borough Hospital
nion Street
bo[illegible]gh, MA 01752
[illegible]ent

Winchester Hospital
41 Highland Avenue
Winchester, MA 01890
1990-Present

ton-Wellesley Hospital
Washington Street
ton, MA 02162
-Present

Saints Memorial Hospital
Hospital Drive
Lowell, MA 01854
1991-Present

bscot Bay Medical Center
Hen Cove Drive
pport, ME 04856
-Present

Milford-Whitinsville Hospital
14 Prospect Street
Milford, MA 01757
12/94-Present

ıte Health Systems, Inc.
Warren Avenue
urn, MA 01801
-Present

McLean Hospital
115 Mill Street
Belmont, MA 02178
9/95-Present

[illegible] Medical Center
[illegible] Road
ıgton, MA 02174
-Present

Beverly Hospital
Herrick Street
Beverly, MA 01915
6/94-Present

ARBOUR-FULLER
HOSPITAL
A Division Of Arbour Health System

May 18, 1998

Michael Franzak
via fax: 602-553-9042

Thank you for sharing information about your Dual Diagnosis Committee Action Grant Proposal. I would be very interested in participating as a consultant if the proposal gets funded.

Attached is my curriculum vitae as requested.

Sincerely,

Kenneth Minkoff, M.D.
Medical Director

KM/cm

BIOGRAPHICAL SKETCH

Provide the following information for the key personnel in the order listed on Form Page 2.
Photocopy this page or follow this format for each person.

NAME	POSITION TITLE
Robert E. Drake	Director, NH-Dartmouth Psychiatric Research Center

EDUCATION (Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)

INSTITUTION AND LOCATION	DEGREE (if applicable)	YEAR(s)	FIELD OF STUDY
Princeton University, Princeton, NJ	B.A.	1971	Biology
Duke University, North Carolina	Ph.D.	1977	Developmental & Clinical Psychology
Duke University, North Carolina	M.D.	1978	Medicine

RESEARCH AND PROFESSIONAL EXPERIENCE: Concluding with present position, list, in chronological order, previous employment, experience, and honors. Include present membership on any Federal Government public advisory committee. List, in chronological order, the titles, all authors, and complete references to all publications during the past three years and to representative earlier publications pertinent to this application. If the list of publications in the last three years exceeds two pages, select the most pertinent publications. DO NOT EXCEED TWO PAGES.

RESEARCH AND PROFESSIONAL EXPERIENCE:

1982-1984	Co-director, Ambulatory Community Service, the Cambridge Hospital. Instructor in Psychiatry, Harvard Medical School.
1984-1990	Medical Director, West Central Community Mental Health Services, Hanover, NH.
1984-	Assistant Professor to Professor of Psychiatry, Dartmouth Medical School.
1987-	Director, New Hampshire-Dartmouth Psychiatric Research Center.
1989-	PI or Co-PI on 17 research grants.

HONORS:

1971	Phi Beta Kappa, Magna Cum Laude, Sigma Xi.
1971-1978	NIH Research Scientist Training Program Fellowship.
1980	Distinguished Dissertation Award, Amer. Psychol. Assoc., Clinical Division.
1981-1982	Dupont-Warren Research Fellowship, Harvard Medical School.
1986 & 1987	Teacher of the Year Award, Dept. of Psychiatry, Dartmouth Medical School.
1989	Community Psychiatrist Achievement Award, Amer. Assoc. Community Psychiatrists.
1989-1994	NIMH Research Scientist Development Award, Level II
1993	Andrew Thomson Professor of Psychiatry, Dartmouth Medical School
1993	Keystone Founders Award, National Conference on Case Management
1995-2000	NIMH Research Scientist Development Award, Level II
1996	System Change Award, New Hampshire AMI
1997	Armin Loeb Research Award, International Assoc. Psychosocial Rehabilitation Services

SELECTED RECENT PUBLICATIONS: (From over 190)

Drake, R.E., McHugo, G.J., Noordsy, D.L. A pilot study of outpatient treatment of alcoholism in schizophrenia: Four-year outcomes. American Journal of Psychiatry, 150:328-329, 1993.

Bartels, S.J., Teague, G.B., Drake, R.E., Clark, R.E., Bush, P., Noordsy, D.L. Service utilization and costs associated with substance abuse among rural schizophrenic patients. Journal of Nervous and Mental Disease, 181:227-232, 1993.

Drake, R.E., Alterman, A.I., Rosenberg, S.R. Detection of substance use disorders in severely mentally ill patients. Community Mental Health Journal, 29:175-192, 1993.

Drake, R.E., Bebout, R.R., Roach, J.P., Quimby, E., Harris, M., Teague, G.B. Process evaluation in the Washington, D.C., dual diagnosis project. Alcoholism Treatment Quarterly, 10(3/4):113-124, 1993.

Drake, R.E., Bartels, S.B., Teague, G.B., Noordsy, D.L., Clark, R.E. Treatment of substance use disorders in severely mentally ill patients. Journal of Nervous and Mental Disease, 181:606-611, 1993.

Drake, R.E., Wallach, M.A. Moderate drinking among people with severe mental illness. Hospital and Community Psychiatry, 44:780-782, 1993.

Clark, R.E., Drake, R.E. Expenditures of time and money by families of people with severe mental illness and substance use disorder. Community Mental Health Journal, 30:145-163, 1994.

Osher, F.C., Drake, R.E., Noordsy, D.L., Teague, G.B., Hurlbut, S.C., Paskus, T.J., Beaudett, M.S. Correlates and outcomes of alcohol use disorder among rural schizophrenic patients. Journal of Clinical Psychiatry, 55:109-113, 1994.

Drake, R.E., Noordsy, D.L. Case management for people with coexisting severe mental disorder and substance use disorder. Psychiatric Annals, 24:27-31, 1994.

Noordsy, D.L., Drake, R.E., Biesanz, J.C., McHugo, G.J. Family history of alcoholism in schizophrenia. Journal of Nervous and Mental Disease, 182:651-655, 1994.

Drake, R.E., McHugo, G.J., Biesanz, J.C. The test-retest reliability of standardized instruments among homeless persons with substance use disorder. Journal of Studies on Alcohol, 56:161-167, 1995.

Bartels, S.J., Drake, R.E., Wallach, M.A. Long-term course of substance use disorders among persons with severe mental disorders. Psychiatric Services, 46:248-251, 1995.

Drake, R.E., Noordsy, D.L. The role of inpatient care for patients with co-occurring severe mental disorder and substance use disorder. Community Mental Health Journal, 31:279-282, 1995.

Teague, G.B., Drake, R.E., Ackerson, T. Evaluating the implementation of a modified PACT model for people with co-occurring severe mental disorder and substance use disorder. Psychiatric Services, 46:689-695, 1995.

McHugo, G.J., Drake, R.E., Burton, H.L., Ackerson, T.H. A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. Journal of Nervous and Mental Disease, 183:560-565, 1995.

Clark, R.E., Drake, R.E., McHugo, G.J., Ackerson, T.H. Financial incentives for assertive community treatment: Mental illness management services. Medical Care, 33:729-738, 1995.

Drake, R.E., Mueser, K., Clark, R.E., Wallach, M.S. The course, treatment, and outcome of substance use disorder in persons with severe mental illness. American Journal of Orthopsychiatry, 66:42-51, 1996.

Drake, R.E. Substance use reduction among patients with severe mental illness. Community Mental Health Journal, 32:311-314, 1996.

Bartels, S.J., Drake, R.E. Residential treatment for dual diagnosis. Journal of Nervous and Mental Disease, 184:379-381, 1996.

Drake, R.E., Mueser, K.T. (Eds.) Dual Diagnosis of Major Mental Illness and Substance Use Disorder, II: Recent Rsearch and Clinical Implications. San Francisco, Jossey-Bass, 1996.

Noordsy, D.L., Schwab, B., Fox, L., Drake, R.E. The role of self-help programs in the rehabilitation of persons with mental illness and substance use disorders. Community Mental Health Journal, 32:71-81, 1996.

Drake, R.E., Mueser, K.T. Alcoholism and severe mental illness. Alcohol Health and Research World, 20:87-93. 1996.

Brunette, M.F., Mueser, K.T., Xie, H., Drake, R.E. Relationships between symptoms of schizophrenia and substance abuse. Journal of Nervous and Mental Disease, 185:13-20, 1997.

Brunette, M.F., Drake, R.E. Gender differences in patients with schizophrenia and substance abuse. Comprehensive Psychiatry, 38:109-116, 1997.

Mueser, K.T., Drake, R.E., Ackerson, T., Alterman, A.I., Miles, K.M., Noordsy, D.L. Antisocial personality disorder, conduct disorder, and substance abuse in schizophrenia. Journal of Abnormal Psychology, 106:473-477, 1997.

Drake, R.E., Yovetich, N.A., Bebout, R.R., Harris, M., McHugo, G.J. Integrated treatment for dually diagnosed homeless adults. Journal of Nervous and Mental Disease, 185:298-305, 1997.

Drake, R.E., Mercer-McFadden, C., McHugo, G.M., Mueser, K.T., Rosenberg, S.D., Clark, R.E., Brunette, M.F. (Eds.) Readings in Dual Diagnosis. Columbia, MD, International Association of Psychosoical Rehabilitation Services, 1998.

Rosenberg, S.D., Drake, R.E., Wolford, G.L., Mueser, K.T., Oxman, T.E., Vidaver, R.M., Carrieri, K.L., Luckoor, R. Dartmouth Assessment of Lifestyle Instrument (DALI): A substance use disorder screen for people with severe mental illness. American Journal of Psychiatry, 155:232-238, 1998.

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2 Whipple Place, Suite 202
Lebanon, New Hampshire 03766
(603) 448-0126
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Dual Diagnosis Publications from the New Hampshire-Dartmouth Psychiatric Research Center, 1989-present

Drake, R.E. Research progress. In Homelessness, Alcohol, and Other Drugs. Rockville, MD: US Department of Health and Human Services, NIAAA, 1989.

Drake, R.E., Osher, F.C., & Wallach, M.A. Alcohol use and abuse in schizophrenia: A prospective community study. Journal of Nervous and Mental Disease, 177, 408-414, 1989.

Drake, R.E., & Wallach, M.A. Substance abuse among the chronic mentally ill. Hospital and Community Psychiatry, 40, 1041-1046, 1989.

Drake, R.E., Wallach, M.A., & Hoffman, J.S. Housing instability and homelessness among aftercare patients of an urban state hospital. Hospital and Community Psychiatry, 40, 46-51, 1989.

Drake, R.E., & Willenbring, M. Case management and clinical research. In Homelessness, Alcohol, and Other Drugs. Rockville, MD: US Department of Health and Human Services, NIAAA, 1989.

Osher, F.C., & Kofoed, L.L. Treatment of patients with psychiatric and psychoactive substance use disorders. Hospital and Community Psychiatry, 40, 1025-1030, 1989.

Teague, G.B., Drake, R.E., & Bartels, S.J. Stress and schizophrenia: A review of research models and findings. Stress Medicine, 5, 153-165, 1989.

Teague, G.B., Mercer-McFadden, C., & Drake, R.E. Dual diagnosis and continuity of care: New Hampshire's integrated initiatives for dual diagnosis patients. Tie Lines, VI, 1-3, 1989.

Bartels, S.J., & Drake, R.E. Depression, hopelessness, and suicidality in schizophrenia: The neglected impact of substance abuse. In C.N. Stephanis, A.D. Rabavials, & C.R. Soldatos (Eds.), Proceedings: VIII World Congress of Psychiatry. Amsterdam: Exerpta Medica, Elsevier Publishers, 1990.

Bartels, S.J., & Drake, R.E. Tarasoff and the dual diagnosis patient. In J.C. Beck (Ed.), Confidentiality vs. the Duty to Protect: Risk of Foreseeable Harm in the Practice of Psychiatry. Washington, D.C.: American Psychiatric Press, 1990.

rake, R.E., Antosca, L., Noordsy, D.L., Bartels, S.J., & Osher, F.C. New Hampshire's specialized services for the dually diagnosed. In K. Minkoff & R.E. Drake (Eds.), Dual Diagnosis of Major Mental Illness and Substance Disorders. ((pp. 57-67). San Francisco: Jossey-Bass, 1991.

Drake, R.E., McLaughlin, P., Pepper, B., & Minkoff, K. Dual diagnosis of major mental illness and substance use disorder: An overview. In K. Minkoff & R.E. Drake (Eds.), Dual Diagnosis of Major Mental Illness and Substance Disorders. (pp. 3-12). San Francisco, 1991.

5. Drake, R.E., Osher, F.C., & Wallach, M.A. Homelessness and dual diagnosis. American Psychologist, 46, 1149-1158, 1991.

6. Drake, R.E., & Vaillant, G.E. Predicting alcoholism and personality disorder in a 33-year longitudinal study of children of alcoholics. Annual Review of Addictions Research and Treatment, 15-23, 1991.

7. Drake, R.E., Wallach, M.A., Teague, G.B., Freeman, D.H., Paskus, T.S., & Clark, T.A. Housing instability and homelessness among rural schizophrenic patients. American Journal of Psychiatry, 148, 330-336, 1991.

8. Kline, J., Harris, M., Bebout, R.R., & Drake, R.E. Contrasting integrated and linkage models of treatment for homeless, dually diagnosed adults. In K. Minkoff & R.E. Drake (Eds.), Dual Diagnosis of Major Mental Illness and Substance Disorder. (pp. 95-106). San Francisco: Jossey-Bass, Inc., 1991.

9. Minkoff, K., & Drake, R.E. Dual Diagnosis of Major Mental Illness and Substance Disorder. San Francisco: Jossey-Bass, 1991.

10. Noordsy, D., & Fox, L. Group intervention techniques for people with dual disorders. Psychosocial Rehabilitation Journal, 15(2), 67-78, 1991.

11. Noordsy, D.L., Drake, R.E., Teague, G.B., Osher, F.C., Huribut, S.C., Beaudett, M.S., & Paskus, T.S. Subjective experiences related to alcohol use among schizophrenics. Journal of Nervous and Mental Disease, 1991.

12. Schwab, B., Clark, R.E., & Drake, R.E. An ethnographic note on clients as parents. Psychosocial Rehabilitation Journal, 15(2), 95-99, 1991.

13. Consensus Panel, Center for Substance Abuse Treatment. Screening, assessment, and treatment planning for patients with co-existing mental illness and alcohol and other drug abuse. Rockville, MD: SAMHSA, 1992.

Group for the Advancement of Psychiatry Psychopathology Committee, Beyond symptom Suppression: Improving the Long-term Outcomes of Schizophrenia. Washington, DC: American Psychiatric Press, 1992.

47. Drake, R.E., Alterman, A.I., & Rosenberg, S.R. Detection of substance abuse in severe mental illness. Community Mental Health Journal, 29, 175-192, 1993.

48. Drake, R.E., Bartels, S.J., & McHugo, G.J. A Seven-year Follow-up Study of Substance Abuse and Homelessness in Patients with Severe Mental Disorders. National Institute on Alcohol Abuse and Alcoholism. Rockville, MD: U.S. Department of Health and Human Services, 1993.

49. Drake, R.E., Bartels, S.B., Teague, G.B., Noordsy, D.L., & Clark, R.E. Treatment of substance abuse in severely mentally ill patients. Journal of Nervous and Mental Disease, 181, 606-611, 1993.

50. Drake, R.E., Bebout, R.R., & Roach, J. A research evaluation of social network case management for homeless persons with dual disorders. In M. Harris & H.C. Bergman (Eds.), Case management: Theory and practice (pp. 83-98). New York: Harwood Academic Publishers, 1993.

51. Drake, R.E., Bebout, R.R., Roach, J.P., Quimby, E., Harris, M., & Teague, G.B. Process evaluation in the Washington, D.C., dual diagnosis project. Alcoholism Treatment Quarterly, 10, 113-124, 1993.

52. Drake, R.E., McHugo, G., & Noordsy, D.L. Treatment of alcoholism among schizophrenic outpatients: Four-year outcomes. American Journal of Psychiatry, 150, 328-329, 1993.

53. Drake, R.E., & Wallach, M.A. Moderate drinking among people with severe mental illness. Hospital & Community Psychiatry, 44, 780-782, 1993.

54. Kushner, M.G., & Mueser, K.T. Psychiatric co-morbidity with alcohol use disorders, Eighth Special Report to the U.S. Congress on Alcohol and Health (Vol. NIH Pub. No. 94-3699, pp. 37-59). Rockville, MD: U.S. Department of Health and Human Services, 1993.

55. McHugo, G.J., Paskus, T.S., & Drake, R.E. Detection of alcoholism in schizophrenia using the MAST. Alcoholism: Clinical And Experimental Research, 17, 187-191, 1993.

56. Clark, R. Family costs associated with severe mental illness and substance use: A comparison of families with and without dual disorders. Hospital and Community Psychiatry, 45, 808-813, 1994.

57. Clark, R.E., & Drake, R.E. Expenditures of time and money by families of people with severe mental illness and substance use disorders. Community Mental Health Journal, 30, 145-163, 1994.

70. Torrey, W.C., & Drake, R.E. Current concepts in the treatment of schizophrenia. Psychiatry, 52, 278-286, 1994.

71. Bartels, S.J., Drake, R.E., & Wallach, M.A. Long-term course of substance use disorders in severe mental illness. Psychiatric Services, 46(3), 248-251, 1995.

72. Bartels, S.J., & Liberto, J. Dual diagnosis in the elderly. In A. Lehman & L. Dixon (Eds.), Double Jeopardy: Chronic Mental Illness and Substance Abuse (pp. 139-157). New York: Harwood Academic Publishers, 1995.

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PROFESSIONAL AFFILIATIONS:

American Psychological Association
American Association of Correctional Psychologists
American Psychology - Law Society
American Correctional Association
National Association of State Mental Health Forensic Directors - Chairman 1986-1988
American Correctional Health Association
American Jail Association

REFERENCES:

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University of Virginia
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Charlottesville, VA 22901
Phone: (804) 924-3632

Henry J. Steadman, Ph.D.
President
Policy Research Associates
262 Delaware Avenue
Delmar, N.Y. 12054
Phone: (518) 439-7415

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President
Threat Assessment Group
537 Newport Center Drive
Newport Beach, CA 92660
Phone: (714)644-3537

ATTACHMENT IV

Joel A. Dvoskin, Ph.D., A.B.P.P.
5174 N. Via de la Lanza
Tucson, Arizona 85750
520-577-3051
Fax: 520-577-3051

May 19, 1998

Michael Franczak
Arizona Department of Health Services
Division of Behavioral Health Services
2122 East Highland
Phoenix, Arizona 85016

Dear Mr. Franczak:

I am happy to provide this letter of support for the Integrated Substance Abuse / Mental Health Community Action Grant. I had the opportunity to observe the tremendous enthusiasm generated during the recent training offered by the GAINS Center, and I feel that your proposal has tremendous potential to improve the lives of Arizonans who are diagnosed with co-occurring disorders. I will be happy to serve as a program consultant to this project, providing advice on program design and implementation issues.

I believe that my experiences in this area will allow me to be of significant use to this project. As you can see from my attached *curriculum vitae*, I directed the forensic and correctional mental health system for the State of New York for more than a decade, and also served as New York State's Acting Commissioner of Mental Health. In addition, I have served as a mental health and criminal justice consultant to state, local, federal, and provincial governmental agencies in more than thirty states and Canada. This experience has allowed me to see a large number of different approaches to meeting the needs of persons with co-occurring disorders and the communities in which they live.

Thank you for involving me in this project. I look forward to hearing from you,

Sincerely,

Joel A. Dvoskin, Ph.D., A.B.P.P.

Dual Diagnosis Staff Capacity Analysis

ADHS/DBHS

Programmatic: The ADHS/DBHS Bureau for Persons with a Serious Mental Illness and the Bureau for General Mental Health/Substance Abuse are co-sponsoring the integrated treatment consensus panel. The Bureau Chief's have also been appointed to a national best practices panel on integrated treatment and have specialized training and experience in this area. Program staff from both Bureaus are provide administrative support to Consensus Panel training and activities, however no existing program staff have the required expertise for implementation, technical assistance and monitoring of RHBA service systems for patients with co-occurring disorders.

Outside Professional Expertise

Consultants in Co-Occurring Disorders: Three national experts in dual diagnosis treatment are currently contracted with ADHS/DBHS to support the work of the Integrated Treatment Consensus Panel. Grant funding continues until October 1999, with the possibility of continuation funding through SFY 2000. However, additional consultation services may be necessary to fully implement and support program strategies during this period, including specialized work with RHBA Medical Directors, case management, and UR/UM staff in clinical standards, levels of care and case management support for a comprehensive system of integrated treatment.

Consultants in Outcome Measurement for Co-Occurring Disorders: The TOPPS project is a three-year grant ending in October 2001. National consultants in design of performance measures for integrated treatment are available to ADHS/DBHS throughout this period and supplement internal DBHS Quality Management Bureau expertise.

Staff Capacity Assessment

Sufficient outside expertise is currently available or can be supplemented to assist in the design of best practice models and clinical care standards for co-occurring treatment. Internal staff expertise is limited to the Bureau Chief positions. Activities necessary to fully implement integrated treatment include development of level of care authorization packages, training and technical assistance support to RBHAs, providers and case managers, and the development of quality monitoring systems (such as specialized case file review procedures). These initiatives will require substantial resources for implementation and maintenance of the system. The addition of one co-funded position rectly focused on integration activities would greatly facilitate the process and ensure ntinuous attention to quality. In addition, if second year grant funding is not forthcoming, additional consultation time may be necessary.

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Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., & Bond, G.R. A integrated mental health and substance abuse treatment for patients disorders. Schizophrenia Bulletin, 24(4), 589-608, 1998.

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., Bond, G.R., McDonel, E.C., Salyers, M., Chen, A., & Miller, L. ertive community treatment: A field experiment. Psychiatric tion Journal, 21(4), 371-379, 1998.

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CURRICULUM VITAE

Joel A. Dvoskin, Ph.D., A.B.P.P.

5174 N. Via de la Lanza
Tucson, Arizona 85750-7077
Phone: 520-577-3051
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EDUCATION:

Undergraduate: University of North Carolina at Chapel Hill; B.A. 1973;
Majors: English and Psychology;
Awards: Order of the Old Well Honorary Society
Order of the Grail Honorary Society.

Stockholm University, Stockholm, Sweden; Diploma, 1972; Major: Social Science.

Graduate: University of Arizona, Tucson, Arizona;
M.A. in Clinical Psychology, 1978; Ph.D. in Clinical Psychology, 1981;
Dissertation: Battered Women: An Epidemiological Study of Spousal Violence.

Professional: University of Arizona College of Law, Tucson, Arizona;
Doctoral Minor (21 semester hours).

HONORS:

Diplomate in Forensic Psychology, American Board of Professional Psychology
Fellow, American Psychological Association
Fellow, American Psychology-Law Society
Peggy Richardson Award, National Coalition for the Mentally Ill in the Criminal Justice System
Amicus Award, American Academy of Psychiatry and the Law

ACADEMIC POSITION:

1996 - current
Assistant Professor (Adjunct) - U. of Arizona Coll. of Law
Assistant Professor (Clinical) - U. of Arizona Coll. of Medicine, Dept. of Psychiatry
1986 - current
Assistant Clinical Professor - New York Univ. Medical School, Dept. of Psychiatry

PROFESSIONAL EXPERIENCE:

September 1995 - Current

Full-time private practice of forensic psychology, providing expert testimony on civil and criminal matters, and consultation in the provision of mental health and criminal justice services, and workplace and community violence prevention programs.
Duties: Provide expert testimony, consultation, training, and public speaking services to federal, state, and local governmental agencies, corporations and attorneys.

September 1995 - Current

Associate, Threat Assessment Group, Newport Beach, California
Duties: Provide consultation and training in workplace violence prevention and crisis management to governmental and corporate organizations.

September 1995 - Current

Associate, Park Dietz Associates, Newport Beach, California
Duties: Forensic psychological services and expert testimony

March 1995 - August 1995

Acting Commissioner, New York State Office of Mental Health
Duties: Under the direct supervision of the Governor, served as C.E.O. of the largest agency of its kind in the United States, with an annual budget of more than $2.4 billion. The agency employs over 24,000 people and directly operates 29 institutions, including adult inpatient and outpatient facilities, children's psychiatric hospitals, forensic hospitals and research institutes. The Office of Mental Health also licenses, regulates, finances, and oversees more than 2,000 locally operated inpatient, emergency, outpatient, and residential programs in collaboration with 57 counties and New York City.

August, 1988 - March 1995

Associate Commissioner for Forensic Services, New York State Office of Mental Health.
Duties: Direct Bureau of Forensic Services (see below).

November, 1984 - August, 1988

Director, Bureau of Forensic Services, New York State Office of Mental Health.
Duties: Line authority for inpatient services at three large forensic hospitals and two regional forensic units, including services to civil, forensic and correctional patients; line authority for all mental health services in New York State prisons; responsibility for innovative community forensic programs including suicide prevention in local jails, police mental health training, and mental health alternatives to incarceration.

December, 1984 - July, 1985

Acting Executive Director, Kirby Forensic Psychiatric Center
Duties: Founding C.E.O. for new maximum security forensic psychiatric hospital in N.Y.C.

er, 1984
cting Director, Office of Mental Health, Virginia Department of Mental Health and
lental Retardation (held concurrently with permanent position as Director of Forensic
ervices).
)uties: Supervision of budget and certification of all community mental health programs
tatewide; statewide policy development in all program areas related to mental health;
Executive Secretary to Virginia Mental Health Advisory Council.

)vember, 1984
)irector of Forensic Services, Virginia Department of Mental Health and Mental
Retardation.
)uties: Design and coordination of statewide delivery system of institutional and
ommunity treatment and evaluation of forensic patients; management of the contract for
he University of Virginia Institute of Law, Psychiatry and Public Policy; departmental
iaison to Virginia Dept. of Corrections and other criminal justice agencies; develop
tatewide plan for delivery of mental health services to D.O.C. inmates; statewide Task
Force on Mental Health Services in Local Jails.

- July, 1983
Psychologist I, Arizona Correctional Training Center, Tucson, Arizona.
D[illegible]: Supervision of psychology department; direct clinical treatment and evaluation
s[illegible]es.

July, 1982
Acting Inmate Management Administrator, Arizona State Prison Complex, Florence,
Arizona.
Duties: Direct supervision of inmate records office; inmate classification and
movement; correctional program (counseling) services; psychology department; hiring of
all new correctional officers. (NOTE: During this period, I also maintained all duties of
my permanent position as Psychologist I (below).

1 - July, 1982
Psychologist I, Arizona State Prison Complex, Florence, Arizona.
Duties: Supervision of Psychology Department for complex consisting of five prisons;
direct clinical treatment and evaluation services.

980 - October, 1981
Psychology Associate II, Arizona State Prison Complex, Florence, Arizona.
Duties: Direct clinical treatment and evaluation services.

) - November, 1980
[illegible]hological consultant to the Massachusetts Department of Correction.
[illegible]ies: Consultation to Director of Health Services; direct clinical treatment and
[illegible]ation services at Walpole and Norfolk State Prisons.

CURI

Janu:

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1978

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mber, 1980
sycnologist - Tri-Cities Community Mental Health Center, Malden, Massachusetts.

August, 1980
re-Doctoral Intern in Clinical Psychology, McLean Hospital, Belmont, Massachusetts;
ıd Fellow in Clinical and Forensic Psychology, Harvard Medical School, Cambridge,
lassachusetts, and Bridgewater (Massachusetts) State Hospital.

sychology Extern, Pima County (Arizona) Superior Court Clinic.

sychology Extern, Palo Verde Hospital, Tucson, Arizona.

'sychology Extern, Arizona Youth Center (now Catalina Mountain School), Tucson,
ırizona.

Jational Institute of Mental Health Trainee.

Jnited States Peace Corps Volunteer, Senegal, West Africa.

h's Carolina Basketball School, Chapel Hill, N.C. (1-3 weeks each summer).

CONSULTATION CLIENTS:

nment -
National Institute of Mental Health
United States Secret Service
United States Department of Justice, Civil Rights Division
National Institute of Justice
National Institute of Corrections

al Governments -

Alabama	Hawaii	New Jersey	Utah
Arizona	Illinois	New Mexico	Vermont
Arkansas	Kentucky	New York	Virginia
California	Maine	Ohio	Washington
Connecticut	Maryland	Pennsylvania	West Virginia
Delaware	Massachusetts	Puerto Rico	Wyoming
District of Columbia	Michigan	South Carolina	
Florida	Missouri	Tennessee	
gia	Nebraska	Texas	

International -
Province of Ontario
Correctional Service of Canada
Province of British Columbia

Professional Organizations -
American Psychiatric Association - Committee on Correctional Psychiatry (Consultant)
American Correctional Association
Arizona Bar Association

Selected Corporate Clients -
American Express
Boise Cascade
Borden Foods
Chase Manhattan Bank
Corning Glass
Johnson and Johnson
Kraft Foods
Levi Strauss
Macy's
Motorola
National Basketball Players Association
National Basketball Association
National Semiconductor
Nationwide Insurance
Nordstrom's
Oracle Corporation
Pillsbury
Sony Corporation
State Farm Insurance
3-M Corporation
Warner Lambert Pharmaceuticals

BOARD MEMBERSHIPS:

Editorial Boards	Bulletin of the American Academy of Psychiatry and the Law
	Journal of Mental Health Administration
	Behavioral Sciences and the Law
	Journal of Aggression, Maltreatment, and Trauma
Research Advisory Board	United States Secret Service
Advisory Board	National Center for State Courts, Institute on Mental Disability and the Law
Member	White House Panel on the Future of African-American Males - 1995

LICENSE

Arizona Board of Psychologist Examiners, License #0931

PUBLICATIONS:

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